DOCUMENT RESUME

ED 476 238 PS 031 114

AUTHOR	Fenichel, Emily, Ed.
TITLE	Paraprofessionals in Infant/Family Practice.
INSTITUTION	Zero to Three: National Center for Infants, Toddlers and Families, Washington, DC.
ISSN	ISSN-0736-8038
PUB DATE	2002-11-00
NOTE	53p.; Published bi-monthly.
AVAILABLE FROM	Zero to Three, % SunTrust Bank, P.O. Box 79768, Baltimore, MD 21279-0768 ($60, one-year subscription, 6 issues). Tel: 800-899-4301 (Toll Free); Tel: 202-638-0840; Fax: 202-638-0851; e-mail: orders@zerotothree.org; Web site: http://www.zerotothree.org.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Zero to Three; v23 n2 Nov 2002
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS
DESCRIPTORS	Adolescents; Breastfeeding; Child Care; Early Parenthood; *Family (Sociological Unit); Family Child Care; *Infants; Low Income; Mothers; Obstetrics; *Paraprofessional Personnel; Parent Education; *Professional Development; Program Descriptions; Social Services; *Toddlers
IDENTIFIERS	Midwives; Nurse Midwives; Traditional Birth Attendants

ABSTRACT

"Zero to Three" is a single focus bulletin of the National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. Noting that sometimes practice needs to be "translated" into research, as with understanding the phenomenon of paraprofessional workers in infant/family service programs, this issue focuses on the complexity of paraprofessional practice in the infant/family field. The featured articles are as follows: (1) "The Professional Development of Paraprofessionals" (Sydney Hans and Jon Korfmacher); (2) "Becoming a Doula" (Erin F. Behnke and Sydney L. Hans); (3) "Benefits and Challenges of Paraprofessional Advocacy with Mothers Who Abuse Alcohol and Drugs and Their Children" (Therese Grant, Ann Streissguth, and Cara Ernst); (4) "The Helping Relationship in a Teen Parenting Program" (Jon Korfmacher and Isabela Marchi);(5) "The Chicago Health Connection's Teen Peer Leader Program: Helping Adolescent Mothers Tell the World about Breastfeeding" (Maryanne Locklin); and (6) "Extended Care: Family Child Care, Family Support, and Community Development in Low-Income Neighborhoods" (Juliet Bromer). Also included is a description of a therapeutic family child care project in rural, southern Illinois (Carol S. Klass). Regular departments in the bulletin list Zero to Three publications, videotapes and on-line resources, and Zero to Three staff announcements. (HTH)

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ED 476 238

ZERO TO THREE®

November 2002
Volume 23 No. 2

Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Paraprofessionals in Infant/Family Practice

Connecting With High-Risk Families

Paraprofessionals as Community Leaders

When Relationships Go Awry

The Professional Development of Paraprofessionals

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Editor's Note

"Translating research into practice" has become a catch phrase throughout the infant/family field – including at ZERO TO THREE. The Guest Editors and contributors to this issue of the *Zero to Three* Journal remind us, however, that from time to time practice needs to be "translated" into research. This is the case when we try, systematically, to understand the phenomenon of paraprofessional workers in infant/family service programs.

The people who help mothers give birth to and nurture their babies have almost always been "paraprofessionals" — family members, midwives, village grannies, and neighbors. Research? Maybe by anthropologists. Now, however, the infant/family field is dealing with: 1) a large body of knowledge about interventions that can increase at-risk infants' chances for healthy developmental outcomes; 2) the simultaneous professionalization of infant/family practice and the "commodification" of many traditional family functions; and 3) the demand for documented outcomes of early intervention efforts. How can we document the work that today's infant/family paraprofessionals are doing in this ever-changing context? And how can we interpret what we document?

Guest Editors for this issue are **Sydney Hans**, Research Associate Professor in the Department of Child Psychiatry, **University of Chicago**, and **Jon Korfmacher**, Assistant Professor, **Erikson Institute**. Hans' research has focused on the factors that influence the early development of children living in high-risk situations. Korfmacher has studied different types of early childhood interventions. Together they have been examining the impact of doula services on pregnant and parenting teen mothers. In this issue of *Zero to Three*, Hans, Korfmacher and their fellow contributors "embrace the complexity" of paraprofessional practice in the infant/family field. They use the special tools of qualitative methodology, either alone or together with quantitative data, to tell us — practitioners, trainers, policy makers, and other researchers — what is important to know about this crucial work. For their remarkable gift to the readers of *Zero to Three*, we are all grateful.

Emily Fenichel

Remembering Al Solnit

It seems as if it were only last week that Al Solnit was sitting at a table above a drugstore in Adelphi, Maryland, at the NIMH Mental Health Study Group offices. He was scheming with the founding 12 Board members of the yet-to-be-named National Center for Clinical Infant Programs (now ZERO TO THREE), trying to create a powerful voice for the overlooked needs of our country's infants and toddlers. With his passing, that original group is now reduced to 7*. Losing Al, one of our major visionaries, is a bitter pill to swallow. He was a unique advocate for children. He got mad. He let many powerful people know that they weren't doing enough, and he convinced many, with the power of his intellect and the passion of his convictions, that young children deserved better. Although Al's voice has been joined by the voices of thousands, there will never be another voice as clear and as forceful as Al's. He was so strong, so forceful, so right in what he had to say. And he said it to those who really needed to hear it. Speaking for the rest of the founders of ZERO TO THREE, I pledge that the passion for the rights of children that Al Solnit lived each day will live on through us, and all the Board members and staff who have joined us and will follow us. Al, you will always be with us.

J. Ronald Lally
Founding Board Member
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ISSN 0736-8038
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Washington, D.C. 20036-3307
Tel: (202) 638-1144
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The Professional Development of Paraprofessionals

Sydney Hans
and
Jon Korfmacher
Guest Editors

Paraprofessional staff who work with infants, toddlers, and their families go by many names, including family advocates, lay helpers, community-level staff, and indigenous workers. They usually come from the same community, or from similar life circumstances, as participants in the programs where they work. Typically, paraprofessional workers do not have degrees or formal training in professional disciplines such as social work, medicine, psychology, nursing, or counseling. They may, in fact, have had little formal education of any kind.

Front-line paraprofessionals are a deeply engrained feature of infant/family service programs in this country. Recently, however, some high-profile program evaluations and summary reviews of the intervention research literature have questioned the use of paraprofessionals in early childhood services. We saw the current controversy as a good opportunity to explore some important issues — for example, the roles of paraprofessionals in different infant/family program models, the training and supervision that paraprofessionals need to function effectively, and the process of their professional growth.

This issue of *Zero to Three* examines the use of paraprofessionals as primary service providers in a range of early childhood intervention models, including home visiting, doula support, family child care, and peer breastfeeding advocacy. To understand different aspects of program experience and to identify the benefits and challenges associated with the use of paraprofessionals, the contributors to this issue use qualitative methodology, either alone or in conjunction with quantitative data. Through intensive observation and interviews, the authors explore the complexities of providing services to families of young children (see sidebar, p. 6). They use service providers' and program participants' own words whenever possible to tell us what it means for paraprofessionals to work with pregnant women, infants, toddlers, and their families.

This introductory essay reviews the controversies surrounding programs for infants, toddlers, and their families that are staffed by paraprofessionals. We focus specifically on what research does and does not tell us about the implementation of such programs and about their impact on the lives of children and families.

Who Are Paraprofessionals?

As noted above, "paraprofessional" is a generic term used to describe a wide variety of service providers. Musick and Stott (2000) use the term paraprofessional to describe workers who do not have baccalaureate, post-baccalaureate, or professional training (see p. 440). Some intervention programs, however, consider as paraprofessional staff those who have some college education or an undergradu-

at a glance

- Front-line paraprofessionals are a deeply engrained feature of infant/family service programs in this country.
- Paraprofessionals in early childhood intervention programs have often experienced the struggles associated with the communities they serve, such as living in poverty.
- In randomized trials, home visiting programs staffed by paraprofessionals generally have not demonstrated strong intervention impacts.
- Ongoing training, individualized supervision, and consistent feedback from administrative staff to paraprofessionals may increase their chances of success.

PHOTO: MARILYN NOLT

ate degree, although typically not in child development or clinical fields (see Wasik, 1993, and Powell, 1993).

The other common characteristic of paraprofessionals is that they tend to come from the same community or life circumstances as the program participants. Many paraprofessional workers in early childhood intervention programs are women, usually mothers, who have experienced the struggles associated with living in or near poverty or other stressful circumstances. They tend to be hired not so much on the basis of prior work experience or educational qualifications but because they possess hard-to-define emotional or personal qualities. As Powell (1993) noted, "lay workers are selected on the basis of their strong ties to local residents and their ability to establish a strong interpersonal relationship with program participants" (p. 35).

Although paid paraprofessional workers have had a role in health and social service programs since the early 20th century, their use has increased in the last 30 to 40 years. When the War on Poverty went into full swing in the late 1960s, community-level programs for low-income families needed staff and hired community residents (Musick & Stott, 2000). A decade later, the family support movement became a forceful presence in social services. This model of early intervention focused on families and neighbors providing mutual support, building on already existing strengths, and respecting local cultural and child-rearing norms (see Halpern, 1999, pp. 180-189). Paraprofessionals from the community seemed, in many ways, ideally qualified to carry out this approach to working with families.

For several reasons, early childhood programs continue to use paraprofessionals as front-line service providers, especially when low-income families are the target population.

1. **Paraprofessionals can bridge the social distance between service programs and high-risk families who are mistrustful of formal social services.** Isolated or tentative families may be more likely to place their trust in someone who comes from their neighborhood, understands their customs and concerns, and has lived through the same types of experiences. Having successfully survived challenges that the participating family is currently experiencing, the paraprofessional serves as role model, demonstrating that it is possible to overcome adversity.
2. **Programs empower communities when they hire local workers.** Paid employment is good in itself. In addition, paraprofessional workers grow, personally and professionally, from the training they receive as staff members and from their increased status as knowledgeable helpers. This is certainly the model of Head Start, where parents can start as classroom volunteers and work their way up to head teachers and administrators. **Bromer**, in this issue, describes the roles that family child care providers play as resources to their communities.
3. **Paraprofessionals are often less expensive.** Their salaries and expectations about benefits are lower than those of professionals, and they may be more willing to work part-time. Programs that are financially strapped (and early childhood programs are *always* financially strapped) can hire a larger workforce to implement their program if they hire paraprofessionals rather than relying on staff with formal training.

In sum, philosophically and economically, paraprofessionals are an attractive option for community programs that are trying to involve a large number of families and have limited resources to do so. Paraprofessionals are seen as a relatively inexpensive way for programs to serve families while remaining grounded in the community. This mixture of pragmatic need and grassroots social activism accounts for much of the popularity of paraprofessionally staffed programs. Large public and private organizations that often use paraprofessionals, such as the Head Start Bureau and Prevent Child Abuse America (which oversees Healthy Families America, a popular home visiting program), give additional standing to these helpers in our early childhood service delivery system.

Why Do Qualitative Research?

Increasingly, program evaluators are relying on qualitative research methods to complement more familiar quantitative research strategies. Each of these approaches has different strengths and different uses within evaluation research.

The articles in this issue use a variety of qualitative methods, such as open-ended interviews with program participants and program staff, observations of focus groups with participants, and field notes from program observation. Qualitative evaluation data can take other forms, including diaries from program participants or staff, materials taken from service records, official program documents or correspondence, and written responses to open-ended questions. The common feature of qualitative research is that the data are in the form of text. By contrast, quantitative evaluation data are in the form of numbers gathered from program records or structured questionnaires completed by program participants and staff.

Quantitative data are analyzed using conventional statistical procedures designed to evaluate the strength of differences between groups or the magnitudes of associations between variables. Statistical tests have become the standard by which the significance of quantitative research findings is judged. Qualitative data are typically analyzed using content analysis — a process that reduces a large volume of material to a core set of meanings. This process involves systematically exploring the text for repetitions of ideas and then developing a classification system for describing those repeated ideas or themes. Qualitative findings are evaluated in terms of whether they are substantively significant — whether they are logically coherent, whether they build in a systematic on an existing knowledge base, and whether they are useful with respect to their original purpose.

Quantitative and qualitative methods serve very different purposes within evaluation research. The strengths of quantitative methods are their objectivity, generalizability, and parsimony. The structured data-gathering instruments of qualitative research can be administered uniformly across research subjects and data can be analyzed by standard statistical procedures with minimal bias. Quantitative data can be gathered from large samples of people and programs. When these large samples are chosen in such a way as to be representative of a larger universe of people and programs, research conclusions can be assumed to apply to that larger group. Quantitative research findings can be summarized concisely in the form of a few numbers. Quantitative methods are best suited for asking theory-oriented questions and testing hypotheses, especially about program impact: Does an intervention work to change an outcome for families, and how much does it cost to achieve a particular benefit? These are the kinds of questions most often asked by academics and policy makers who are deciding whether to support funding of program initiatives.

The strengths of qualitative research methods are their flexibility, sensitivity to context, and richness. Data gathering is done so as to be open to new ideas that emerge during the course of the research and to allow the voices of the research participants to be heard, even when they express views that differ from those held by the researcher. In qualitative research, the program context is always clearly described as a backdrop for the presentation of the data. Samples for qualitative research are chosen not to be large and representative of a population, but to provide the richest possible information about a topic or to illuminate contrasts of particular interest. Because qualitative data are often presented in the form of quotations or strong descriptions of observations, research reports tend to speak powerfully to readers, particularly readers such as program funders, administrators, and practitioners who are not themselves researchers. Qualitative research methods are best suited for exploring new program models and for addressing practical and action-oriented questions, especially about program implementation: How and why do program models work? These are the kinds of questions most often asked by program administrators and staff.

Readers interested in learning more about qualitative research methods should consult Patton (2002) or Denzin & Lincoln (2000).

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Concerns About Paraprofessionals in Early Childhood Interventions

Despite the fact that many early childhood intervention programs employ paraprofessionals, recent research literature and program evaluation reports often do not support their use. In the late 1970s and early 1980s, reviews and meta-analyses of programs serving individuals and families across the lifespan found few differences between professionals and non-professionals in terms of client outcomes (e.g., Durlak, 1979; Hattie, Sharpley, & Rogers, 1984). Program developers extrapolated these findings to recommend the use of paraprofessionals in early childhood programs. However, recent reviews of paraprofessionally staffed interventions targeted toward families *with young children* — particularly programs that use paraprofessional home visitors — have not been as favorable (Olds & Kitzman, 1993; Gomby, Culross, & Behrman, 1999). In randomized trials, home visiting programs staffed by paraprofessionals generally have not demonstrated strong intervention impacts, have shown higher rates of staff turnover, and have more participant dropouts than programs staffed by professionals.

We caution early childhood programs not to cut corners on supervision, support, and training for paraprofessionals.

We do not know the precise reasons for these findings, but one can make some reasonable guesses. The programmatic challenges of using paraprofessionals have been discussed in detail elsewhere (Musick & Stott, 1990; Hiatt, Sampson, & Baird, 1997; Musick & Stott, 2000). For example, paraprofessional home visitors may not have the knowledge base or expertise to offer child development information effectively. They may struggle to accept a model of parenting, advanced by the intervention program they work for, that does not match their own personal beliefs and feelings. Musick & Stott (1990, 2000) and Halpern (1990) have observed that programs staffed by paraprofessionals can be characterized by "domains of silence" — paraprofessionals may avoid discussing topics that can be very important to families with infants and toddlers such as domestic violence, sexual abuse, and family planning because such subjects are emotionally loaded and personally threatening for workers without the training to deal with them. Paraprofessionals may have difficulties managing their time, organizing paperwork, and prioritizing families within large caseloads. Developing a "professional work ethic" can be challenging for workers if this is their first real job, if they have young children and themselves live on the edge of poverty and financial crisis, or if they feel that their salaries are not commensurate with the expectations of their work.

All of these difficulties may be exacerbated by the stressful, emotionally challenging work of early childhood intervention. Even in programs intended to prevent rather than to remediate child and family problems, families often enroll with a seemingly overwhelming set of social, emotional, and economic difficulties. As the Committee on Integrating the Science of Early Childhood Development recently observed (Phillips & Shonkoff, 2000), the ability to handle the many different problems that families enrolled in early childhood programs face "typically requires a level of professional expertise that exceeds the generic skills of a child care provider, early childhood educator, child protective services worker, or nonprofessional home visitor" (p. 365).

What Should Be Done?

These challenges do not mean that programs should abandon paraprofessionals as service providers. For one thing, there *are* examples in the research literature of paraprofessionally staffed early childhood programs that work. Interventions that have circumscribed roles for paraprofessionals and that focus on more narrowly targeted interventions may have a better chance of meeting their objectives than more global approaches. Consider, for example, the use of peer counselors to encourage breastfeeding among women with traditionally low rates of breastfeeding who have not been effectively reached by medical professionals (see, for example, Kistin, Abramson, & Dublin, 1994; Morrow et al., 1999). Given the stigma associated with breastfeeding in many of these populations, receiving information and encouragement from a person within the mother's community who understands the contextual challenges of and barriers to breastfeeding may be more valuable than receiving similar information from professionals. **Locklin**, in this issue, highlights how *teenaged* peer advocates learn to encourage breastfeeding among other adolescent mothers.

Programs that make a commitment to comprehensive and ongoing training, individualized supervision, and consistent feedback from administrative staff to paraprofessional providers may also increase their chances of success. In this issue, **Grant** and colleagues describe a program that helps paraprofessionals work effectively with difficult-to-reach, substance-abusing families. The type of support this program provides its workers, of course, increases the costs of running a paraprofessionally staffed early childhood program, which may make it more the exception than the rule.

The Professional Development of the Paraprofessional

This discussion leads us to a major theme of this issue — how paraprofessionals develop a "professional" identity as effective helpers of families. If the field (albeit loosely defined) of early childhood intervention continues to use

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paraprofessionals, we need a clearer sense of how these helpers should be trained and supported, and how they can come into their own within a community of providers. In this issue, **Behnke** and **Hans** provide an example of one training program that had a transformative effect on community women who were learning to be doulas, although not all women who wanted to be doulas were able to negotiate this transformation.

We caution early childhood programs not to cut corners on supervision, support, and training (see Klein & Gilkerson, 2000). Paraprofessionals have a difficult job to do, and very often programs rely on their intuitive "people" skills and their deep concern for the well-being of families in their community to get the job done. As **Korfmacher** and **Marchi** (this issue) suggest, there are times when this strategy can work very well, but other times when helpers are left dealing with very difficult and contradictory feelings they have towards families in their caseloads.

If we believe that early childhood intervention is an important part of the array of services offered to children and families, and if early childhood programs continue to employ paraprofessionals, then we need to recognize the complexities of their role and the services they provide. Helpers who come from the communities they serve have something to offer families that can both overlap and complement what professionals bring. We hope that the articles in this issue help the field to acknowledge these complexities and suggest ways of effectively supporting paraprofessionals in the help they provide to infants and families.

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BECOMING A DOULA

ERIN FITZPATRICK BEHNKE, MA
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A doula is a woman, usually a mother, who provides continuous physical, emotional, and informational support to a woman during labor, delivery, and the postpartum period. A growing body of research suggests that when women are supported by a doula, their labors are shorter and less medically complicated and they feel more confident and less depressed in the days and weeks after giving birth (Sosa, Kennell, Klaus, Robertson, & Urretia, 1980; Kennel, Klaus, McGrath, & Hinkley, 1991; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1997; Wolman, Chalmers, Hofmeyr, & Nikodem, 1993).

The Chicago Doula Project (Glink, 1998, 1999) not only works with mothers during labor, but also during the period following birth. Research and theory on early intervention programs strongly suggest that the relationship between service provider and recipient is a crucial agent of change (Barnard, 1998; Bernstein, Percansky, & Wechsler, 1996; Heinicke et al., 2000; Olds & Kitzman, 1993). In light of these findings, paraprofessional doulas in the Chicago Doula Project begin working with young mothers during pregnancy to establish a trusting relationship with the mothers and their family members and to help them prepare for childbirth and parenthood. Doulas continued to work with mothers several months postpartum to support them in breastfeeding and other aspects of parenting.

We gratefully acknowledge the support of the Harris Foundation and the Maternal and Child Health Bureau in conducting this work. We thank Linda Henson for her support and feedback, and the doulas who were willing to share their thoughts and feelings with us and with others.

Supporters of paraprofessional helping models argue that a helper and a client who share a common background may be able to establish a strong helping relationship because the helper understands the client's struggles, making it far more likely that the client will be willing to engage in an intervention and accept help (see Hans & Korfmacher, this issue). The backgrounds of Chicago Doula Project doulas are similar to those of their clients in a number of ways: They may live in the same community, have the same racial and economic background, or have had common life experiences, such as having first given birth during adolescence.

Chicago Doula Project doulas, like many paraprofessional helpers, occupy roles that are complex and challenging. Doulas must have extensive knowledge about pregnancy,

at a glance

- A doula provides physical, emotional, and informational support to a woman before birth, during labor, and in the perinatal period.
- Research has shown that when women are supported by a doula, they experience shorter, less medically complicated labors and less depression after birth.
- In the Chicago Health Project, successful doulas wanted to help others, were open-minded and creative, and were able to learn from the past and accept help.
- Emotional change may be more important than acquiring technical skills in becoming a doula.

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childbirth, and parenting. During labor and delivery, doulas work long hours performing physically demanding activities — massaging the mother's back, helping her breathe through contractions, and praising her hard work in the last stages of labor. Interpersonal challenges frequently arise while dealing with adolescent clients, clients' families and partners, and staff at clinics and hospitals. The work — helping young clients negotiate the worries of pregnancy and childbirth, followed by the emotional early weeks of parenthood within already stressful circumstances — can be emotionally exhausting.

Doulas in the Chicago Doula Project go through an intensive 4-month training program offered by the Chicago Health Connection, a health advocacy and peer counselor training organization. Working with small groups of trainees, teams of trainers provide doulas with an information base about pregnancy and childbirth, and involve them in classroom exercises, personal exploration and sharing, and supervised experiences with clients. The training is designed to be intimate, evocative, emotional, and intense — just like doula work.

Paraprofessionals frequently associate significant personal growth with their training and work experiences. They connect their training to higher self-esteem, greater personal and professional aspirations, and the ability to engage in more effective interpersonal relationships (Halpern, 1995). Yet we know very little about the *process of transformation* that may occur as individuals begin to take on the role of helper, or of *the factors* that are associated with success in becoming a paraprofessional helper. In this article, we describe some of the developmental challenges and changes experienced by women who are learning to become doulas.

Methods for the Present Study

We interviewed 5 women who had been selected for doula training at one of the program sites of the Chicago Doula Project. (The letters A through E are used to identify each of the women in the sections that follow.) Chicago Health Connection staff selected these women for training from a larger pool of applicants because of their strong interpersonal skills and their interest in pregnancy, childbirth, and breastfeeding. All 5 women are African American, and were, at the time of the study, between 28 and 53 years of age. All had completed high school or a GED program. The women had diverse previous work experiences, but none had a stated professional identity at the time they entered training. All 5 women were mothers; 4 had first given birth as adolescents.

We conducted 4 semi-structured interviews averaging 1 hour in length with each woman during training: 1) at the beginning of training; 2) following the first interaction with clients in the prenatal clinics; 3) following the first observation of a birth; and 4) following the completion of training, when doula practice was beginning. The interviews spanned a period of approximately 6 months. Open-ended questions focused on the doula's personal history; work experience; experiences in childbirth and parenting; attitudes towards young mothers and work with young mothers; breastfeeding and/or bottle-feeding experiences; issues of social and community involvement; and the experience of the group training model. Interviews were audiotaped and transcribed. In systematic analyses, researchers extracted salient themes from each set of transcripts, and integrated emerging issues from early interviews into the protocol for subsequent interviews. We have illustrated themes with quotations from the trainees and placed emphasis on themes that emerged across interviews and trainees.

Our research design had not anticipated the possibility that all 5 carefully selected trainees might not complete training and begin work as doulas (see Korfmacher & Marchi, this issue, for another discussion of how staff changes altered the focus of a qualitative study). In fact, only 3 women became doulas. One woman withdrew from the training halfway through while another was counseled by training staff to pursue other kinds of employment. This paper attempts to explore factors that differentiated the women who became doulas from those for whom the work was not a good fit.

Becoming a Doula

All 5 women could assimilate and make use of the technical information about pregnancy and childbirth that was covered in the training program. The trainees varied, however, in their ability to manage the emotional and motivational aspects of training and doula practice. Our analysis of the interviews identified 6 characteristics that distinguished the 3 successful trainees from their colleagues:

1. other-oriented motivation behind the desire to work as a doula;
2. open attitudes toward young mothers;
3. flexible approaches to problem-solving;
4. capacity to accept help and support from others;
5. capacity to make positive meaning of difficult past experiences; and
6. enthusiastically embracing a new identity.

Other-oriented motivation for the work. From the beginning of their training, all 3 women who went on to become doulas articulated strongly that their primary reason for wanting to be a doula was to make a difference in the lives of others. One woman (D) said, "[I want] to make a difference — to be there with the teen mother to comfort her and encourage her and reassure the family." Three women were able to draw upon a sense of fulfillment and gratification from their work for internal motivation as they encountered the intense, challenging, trying, and emotionally evocative practice of being a doula.

Over time, the 3 successful trainees became increasingly aware of and able to describe the connection between their own experiences as mothers and their desire to become a doula — someone who would help another woman become a mother. They began to appreciate how their own experiences had prepared them to make positive and important contributions to the lives of young mothers. Training and reflective

supervision helped these women see their personal histories in a new light and to use their own experiences as a powerful resource of strength and information upon which to draw. One trainee (B) described how she drew upon her own experiences in order to give something to her clients: "Just interacting with the other girls and listening to their stories and the things that have happened in their lives and just reflecting back. A lot of things I would have changed. I would have did different. It's my way of giving what I never had."

In contrast, the 2 women who did not continue with doula work gave more practical and self-oriented explanations for why they had entered the training program. They spoke of their wish for more education, their need for income, their desire for a job that was not in an office, and their positive feelings about their new place of employment. One trainee (E) said: "This will be good for me. It's not a 9-to-5 office thing. It's with [name of employer], and you meet so many people. I do want to quit my job." Another (A) said, "It's a job, for one thing. I need something to do. It's not that far from home. I've always wanted to work at [name of employer]. It's convenient, and I need income." By themselves, these motivations do not appear sufficient for a completion of doula training and successful work experience.

Open attitudes toward young mothers. At the beginning of training, all 5 trainees used words such as "difficult," "stubborn," "hard to reach," and "hard to get through to" to describe teen mothers. They believed that young women became pregnant because they were promiscuous, wanted attention, wanted to have "that little person to love," or needed to have something all their own. Over the course of the training, however, the perspectives of the 3 women who became doulas changed. Their attitudes toward their clients became more flexible and revealed an ability to accept different reasons why young mothers become pregnant. Reflecting back over the course of the training, one doula (C) said:

> *I'm not as judgmental. We don't know what these ladies' backgrounds are. We don't know why they became pregnant. You got to look a little deeper, to show a little empathy as well. Being pregnant is just the tip of the iceberg.*

Differences in attitudes toward young mothers seemed closely linked to the doulas' models for how helping occurs and whether young mothers needed guidance and support, in contrast to needing to be told what to do and how to do it. Doulas who came to view early parenthood as more normative talked of reaching in and harnessing the young mothers' innate and emerging potential:

> *They need guidance. They have as much to offer as we do. We just need to be there to kind of help them along to mature women. You know, they are like a little seed or a tree branch. We should be there to help nurture and comfort and support them.* [D]

For the 3 women who successfully completed training, their new understanding of young mothers in general, their perspective on young mothers' motivations for becoming pregnant, and their beliefs about what young mothers needed served as crucial "information" that they relied on to guide their work. The other 2 trainees continued to view early parenthood as a mistake, and spoke of lecturing stubborn and wayward young women in order to "set them straight." For example, one trainee (A) commented: "As a teen you need to have somebody else to tell you what to do. It will make all the difference. And a lot of the time it does." Her rigid beliefs about what had gone wrong and what needed to be fixed led to frustrations and impasses that seemed to undermine the woman's ability to work effectively as a helper.

Flexible approaches to problem solving. In their work, doulas often are confronted with challenging or frustrating interpersonal situations. For mothers and families, the prenatal, birth, and postpartum periods are highly charged with emotion. The doula sometimes bears the brunt of their emotions, including fear, anger, and despair. Nurses and doctors may confront the doula with their own waves of emotionality, skepticism, and stress. The 3 doulas who were most successful became increasingly self-aware during the course of training. One successful doula (B) recalled asking herself, "How am I going to solve this problem?" Another (C) remembered, "So I left out — sat outside for a while and tried to think of a strategy to use."

The doula sometimes bears the brunt of young mothers' emotions, including fear, anger, and despair.

Essential to the process of effective problem-solving is the capacity to be resilient and non-defensive — not to react by blaming clients or family members, not to take problems as a sign of personal failure, and not to give up. One doula (C) told us:

> *You try to explain. They don't want to hear. It's really hard to get through. It can be frustrating. You just grin and bear it, just try to be persistent and not pushy, just try to find different avenues to reach them. You know if this doesn't work, I'm going to try this, if this doesn't work, I'm gonna try this.*

The 3 successful doulas regarded barriers erected by young mothers or others as opportunities to be creative, employ new strategies, and — often — ultimately experience success. The following vignette illustrates one doula's (C) successful, flexible, and creative approach to a situation in which a grandmother did not respect her daughter's wishes for the doula to be present during labor.

> [The grandmother said], *"How old are you? We got it from here. We don't need anybody in* [the labor room]." *I*

said [to myself], *"Okay, now how am I going to do this?" So I thought, what I'll do is every 15 minutes, check and see if she needs anything. And while I was in there, I started looking around the room and seeing what she might need that she did not have. In those 15 minutes I can bring each piece, which would give me a reason to come back in to check. She didn't have any ice, any pillows, an extra blanket. So in each 15-minute increment I brought her one of those. And they were able to see I wasn't there to tell them what to do, but was there to help the young lady. And when they seen me with those things I was able to come into the room. I was able to show them how to massage her back and the grandmother even turned around and asked me, "How do I do this?" They realized that I was not there to replace the support system that she has, but was there to add to the support system that she has, to give her all of the support.*

This doula was able to understand the perspective of the grandmother and patiently develop a strategy for working with her. In contrast, the 2 trainees who did not continue work as doulas tended to blame families for frustrating encounters and feelings of personal hurt; they then pulled away from the families.

Capacity to accept help from others. The Chicago Doula Project model of helping relies on the capacity of one woman to care for and nurture another. Through experiencing this care, the mother learns to care for and to nurture her child. To provide this help, a doula must be able herself to experience care and nurturing from others.

Effective helpers value and accept the help and support given to them. Supports for doulas may come from families and friends, but also from supervisors and coworkers. Although an important part of becoming a successful helper is the ability to operate independently, even more important is the ability to work as a part of a team. The trainees who went on to become doulas recognized early in their training the importance not only of supporting their colleagues, but also of receiving support. They commented, "We are learning to take care of young mothers by being taken care of by the group" (D), and "We are learning about being a doula by being supported and taken care of by each other" (B). The support and care that trainees receive from the group they then give to the young mothers, who, it is hoped, give this kind of support and care to their babies in turn. Thus, a doula's willingness to receive help from her colleagues provides a model for a young mother to accept help from her doula.

One of the trainees who did not continue to work as a doula lacked access to adequate support at home and felt easily overwhelmed by her work. The other had access to support from others, but was not open to accepting it, and found herself isolated in her work and frustrated in her ability to persuade clients to be open and accepting of help.

Capacity to make positive meaning of difficult past experiences. The women hired in the Chicago Doula Project come from backgrounds that resemble those of their clients. This similarity can be enormously helpful in fostering rapport between doula and client and lies at the core of the program's helping model. But for the trainees, the similarity can also evoke powerful feelings and memories of difficult life experiences.

In their training experience and early work with clients, all doula trainees found themselves revisiting previous painful life experiences. The training and work with clients brought back memories of difficult times — for example, mourning the loss of a pregnancy or a baby, caring for a gravely ill child, feeling disappointment with their children's fathers, or experiencing violence at the hands of a family member. The 3 women who became doulas came to see their personal struggles and losses as opportunities for personal growth. Over the course of the training, these experiences were transformed into powerful sources of insight and inspiration. Doula training and practice enabled these women to identify and use previously unknown or inaccessible strengths and capabilities. One trainee (C) captured the restorative, healing, and growth-promoting power of the training experience in these words: "I feel like I have lived my whole life with a breathing problem. This training was like for the first time I have received an inhaler, opening passageways to be able to breathe freely, talk freely."

In contrast, another trainee was unable to embrace emotional aspects of personal loss and disappointment. For this woman, who had lost a child in infancy, the experience of working with pregnant women was too emotionally intense: She decided to withdraw from training.

Enthusiastically embracing a new identity. In addition to revisiting and redefining past experiences, doula training means accepting a new identity for the future. Integrating new information, new relationships, and new professional responsibilities is an important part of becoming a doula.

In interviews, the 3 women who became doulas all spoke about how they were changing in fundamental ways, particularly in the emotional realm. They said that doula training changed their thinking, enabled them to take risks, made them feel understood and heard, and nurtured them. These women reported that the prospect of becoming a doula was altering the way they thought and felt about themselves, about their past personal and work experiences, and about their relationships with others in their current lives. As a result of these altered perceptions, the trainees revealed increased self-pride, excitement and optimism about their future, and enthusiasm for this new profession. One doula (B), described her experience with a young mother in these words:

She looked over at me, and she said, "I didn't want anybody here at first but I'm so glad that you were here," and that just — aaahhh! — I was on Cloud 9 for the rest of day! That was great! That was great! I can make a difference!

Another doula (D), after being introduced to a patient by a nurse as a "coworker," remarked:

I am like "Oh, my God!" It's easy for an individual to go

on this ego trip, but that is not what it's about. It's about the teens. It's hard not to stick your chest out a little, you know, so you just have to keep your ground. I feel proud. I finally have something, you know, that I can do.

An emerging identity as someone who plays a valuable and valued role helping other individuals seemed to be a central experience of doula training for the 3 women who successfully became doulas. They all showed enthusiasm for professional growth and change — an enthusiasm that one hopes they would communicate to their young clients. In contrast, the 2 women who did not become doulas told interviewers that the greatest reward of doula training was gaining technical knowledge. These trainees, who were unable to make the transition from trainee to helper, did not report a significant transformation in their feelings about themselves or their futures, and sometimes seemed threatened by or resistant to change. For example, when asked if she felt she had changed over the course of the training, one of these women (E) replied, "No, it didn't take hold, I guess. Nothing has changed." The training experience brought about little change in how 2 of the women viewed either themselves or their potential for future work.

Implications for Practice

The themes outlined above, drawn from interviews with women as they were learning to become doulas, have implications for practice in other programs employing paraprofessional helpers. Some of the findings relate to program decisions about who should be hired for this work. The women who were up to the challenges of doula work could not be identified at the beginning of their training on the basis of employment history, education, or age. However, 2 personal characteristics did predict their successful transition to working as doulas:

1. **A strong desire to help other people.** Only women who came to the work motivated by a desire to help more than by a desire for professional advancement had the motivation required to work long hours under challenging circumstances.
2. **Flexibility and emotional availability.** The successful doulas (B, C, and D) referred to this characteristic in themselves as "openness." Doulas needed to be open and accepting of whatever their young clients brought to them, open to help from others, able not to take rejection personally, and creative in problem-solving when their initial plans did not work.

The findings presented in this article have even greater relevance to issues of how helpers should be trained and supervised. Compared to other training programs for paraprofessionals, the Chicago Doula Project training model is long and intensive. It emphasizes practical experiences and offers opportunity to reflect. Paraprofessional helpers usually spend only brief periods of time in formal training for their work — far less than the years that professionals spend in classrooms and internships. Customary brief training for paraprofessionals may simply reflect what programs with limited budgets can afford, but the model also may be rooted in a belief that paraprofessionals' real strengths come from skills acquired outside the workplace rather than those learned in a training setting. The themes outlined in this article suggest that paraprofessionals do experience substantial learning and development as they train and begin their work as helpers, and also that, if not properly nurtured, they are vulnerable to frustration.

Two key insights come from the themes presented in this article that are relevant for training and supervision:

1. **The crucial change that occurs during the transition to helping work is an emotional change — not the learning of new skills.** Doulas need time to process and integrate their feelings, think about their own life histories, and reflect on their reactions to their clients and their work. Ideally, they will find a way to draw on their own backgrounds as a source of motivation, commitment, and tolerance.
2. **Helpers need emotional support at every point of their training and work with families.** There must be frequent opportunities during training and practice for trainees to receive support from others — trainers, supervisors, and peers. Supportive training and supervision are critical, not only to the well-being of the doulas, but, as the doulas themselves noted, to the well-being of the mothers and infants that they serve. ◆

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Benefits and Challenges of Paraprofessional Advocacy

With Mothers Who Abuse Alcohol and Drugs and Their Children

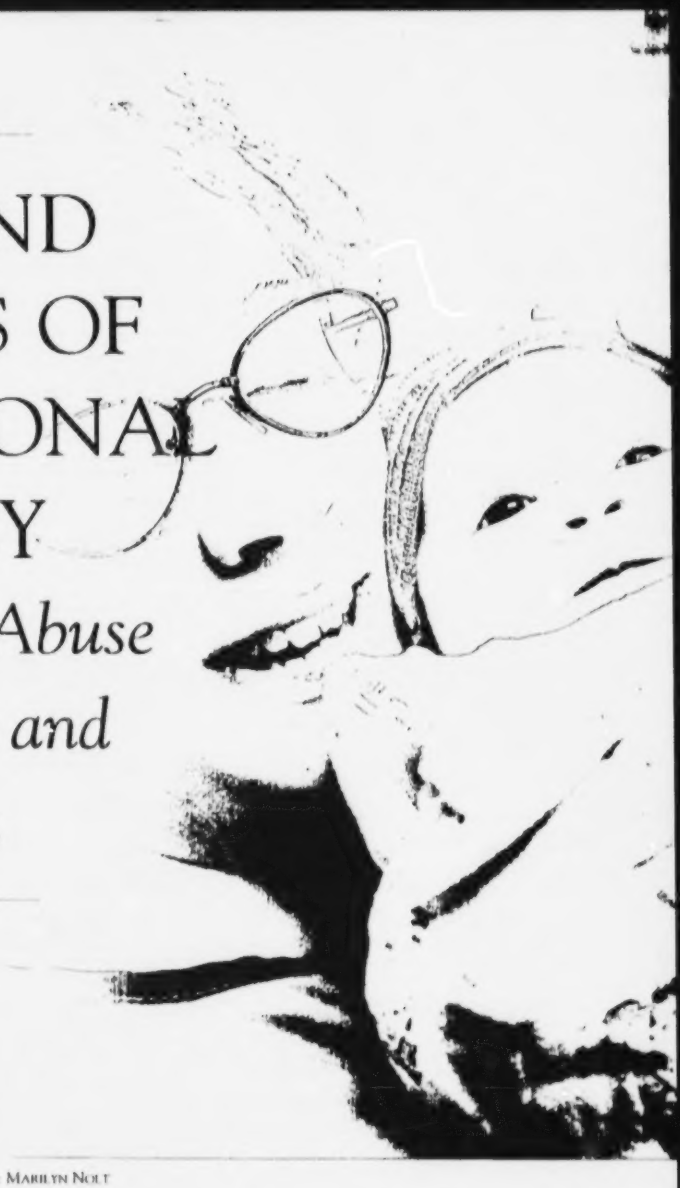

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Photo: Marilyn Nolt

There were times when I felt like I was going to relapse and my advocate would be there for me, and she'd keep checking on me and I'd get through it. I've learned so much about myself and being responsible again and being a good mother. It was all what she taught me — she changed my life for me.
— Parent–Child Assistance Program Client

My advocate taught me a lot of things. She knew what it was like to be a single parent — showing me that I couldn't do the drugs and parent at the same time.
— Parent–Child Assistance Program Client

When a mother abuses alcohol and drugs, she places her child at great risk. Prenatal exposure to alcohol and drugs can have lifelong effects on the health of a child. A mother who abuses substances may have difficulty caring for her child and providing a safe, stable environment. Moreover, mothers who abuse alcohol and drugs tend to continue to bear children, each of whom will be exposed and affected in turn.

Unfortunately, mothers who are dependent on alcohol and drugs — many of whom have concurrent mental health problems — may be those least likely to seek and receive help from community service providers. These mothers sorely need comprehensive services and support and are likely to deliver children at risk for a host of problems. Yet mothers feel alienated from health and social

We are deeply grateful to the advocates and clinical supervisors of the Parent–Child Assistance Program and to the mothers enrolled in the program for their contributions to this work. The authors also wish to thank Julie Pedersen, Nancy Whitney, Pallas Weber, Mary Jo Austin, and Alonah Fernandez for technical assistance. This work was supported by contracts from the State of Washington Department of Social and Health Services (DSHS) #7141-1 and #6376-0 and a grant from the March of Dimes, Washington State Chapter.

service agencies and professionals, and professionals typically experience working with these women as challenging, difficult, or, in some cases, "impossible."

The Parent–Child Assistance Program (PCAP) disproves the notion that mothers who are dependent on alcohol and drugs are hopeless or impossible, and demonstrates how paraprofessional advocates can work effectively with these women (Ernst, Grant, Streissguth, & Sampson, 1999; Grant, Ernst, & Streissguth, 1999). This article describes the theoretical framework and operationalization of the PCAP model, explores the viewpoints of paraprofessional advocates as they put the model into practice, and describes the nature of the relationship between client and paraprofessional home visitor from both a quantitative and a qualitative perspective. The client comments in this article came from planned program exit interviews. Advocate comments came both from interviews conducted with the first author (PCAP's program director) that complemented the client's exit interview and from interviews taped for a 30-minute informational video about the program.

Paraprofessional Intervention

The Parent–Child Assistance Program (PCAP, originally known as the Seattle Birth to 3 Project) began in 1991 as a 5-year federally funded research demonstration project designed to test the efficacy of a model of intensive, long-term paraprofessional advocacy with very high-risk mothers who abuse alcohol or drugs heavily during pregnancy and are estranged from community service providers. Mothers are enrolled in PCAP during pregnancy or within a month after delivery. The primary goal of the program is straightforward — to prevent alcohol and drug exposure among the future children of these mothers. In 1996, on the basis of demonstrated positive outcomes, the Washington State legislature appropriated funds for continuation of the Seattle program and expansion to a second site; in 1999, 2 additional sites were funded, creating a capacity to serve 360 families statewide. PCAP has been replicated at a dozen sites in the United States and Canada.

In the PCAP model, paraprofessional advocates are the interveners.[1] Each advocate works with a caseload of 15 families for 3 years, beginning at enrollment. Advocates receive initial and ongoing training, and are clinically supervised by a master's degree–level professional in social work, mental health, or chemical dependency treatment. The model uses a case management approach to help mothers reduce the spectrum of risk behaviors associated with substance abuse and to increase protective factors to enhance the health and social well-being of the mothers and their children. PCAP does not provide direct substance abuse treatment or clinical services. Instead, the program offers consistent home visitation and links women and their families with a comprehensive array of existing community resources, with an emphasis on alcohol and drug treatment, family planning, housing, health care, parenting, and legal resources. Advocates visit client homes frequently during the first 6 weeks, and then approximately twice a month, depending on client needs. They transport clients and their children to important appointments and work actively within the context of the extended family. Advocates trace clients who are missing, stay in contact with the clients' family members, and provide advocacy services for the infant regardless of who has custody. Clients are never asked to leave the program because of relapses or setbacks.

Theoretical Foundations

Case management and practical assistance alone do not meet the needs of mothers who have experienced as children many of the devastating circumstances their own children are now experiencing: chronic familial substance abuse, poverty, violence, and neglect. Therefore, the PCAP advocacy model offers personalized, caring support over 3 years, a period of time long enough for the process of gradual and realistic change. When we ask clients who are graduating from PCAP what made this program work for them, we hear one consistent response: the advocate's persistence. Over and over again, clients voice a version of this statement: "My advocate never gave up on me. She kept believing in me until I finally started to believe in myself."

The PCAP model draws on concepts of relational theory, which emphasizes the importance of positive interpersonal relationships in a woman's growth, development, and definition of self (Miller, 1991) during her addiction, treatment,

at a glance

- Mothers with alcohol and drug problems may be those least likely to seek help and most likely to be considered "hopeless" or "impossible" by programs.
- Advocates in Seattle's Parent–Child Assistance Program (PCAP) help clients negotiate their treatment and learn to trust.
- Each PCAP advocate has faced at least 1 significant obstacle, such as domestic violence, and overcome it.
- PCAP clients ascribe the program's success to its 3-year span; PCAP advocates to ongoing training, weekly staff and supervisor meetings, and client feedback.

1 The recent resurgence of early intervention home visitation programs to improve the health and welfare of disadvantaged families has been accompanied by debate regarding the relative merits of professional versus paraprofessional providers (Korfmacher, O'Brien, Hiatt, & Olds, 1999). Both models have advantages. On the one hand, professionally credentialed home visitors carry authority and instill trust on the basis of their expertise. Paraprofessionals with shared history and cultural experiences, on the other hand, may understand clients in a way that allows them to gain access and build rapport with women who might otherwise be unapproachable. Regardless of professional status, the background, level of training and supervision, personal characteristics of the home visitor, and staff turnover rate may influence program delivery and outcomes (Gomby, Culross, & Behrman, 1999; Hiatt, Sampson, & Baird, 1997).

and recovery (Finkelstein, 1993). It proposes the idea that paraprofessionals who share some history and life experiences with their clients can play a unique and therapeutic role in 2 ways: 1) by helping clients become connected to another person in a trusting, healthy relationship for perhaps the first time in their lives, and 2) by bridging the gap between high-risk families and the services they need, but are unlikely to obtain without assistance. The intervention also incorporates stages-of-change theory and motivational interviewing strategies. The PCAP approach recognizes that clients will be at different stages of readiness for change at different times, and that ambivalence about changing addictive behavior is normal (Miller & Rollnick, 1991).

> *This work takes a lot of mental energy. You have to be feeling, you have to be knowing and understanding. You need to have a plan, but you have to let the client figure out the plan for herself. You wait for that tiny indication that she sees the way and is ready to change. Then you reach out at the right time to help her move along. I have hope and faith in people. I really believe they want to change if they say they do.* — PCAP advocate

Stages-of-change theory and the constructs of self-efficacy theory dovetail. Both help to explain how home visitors and paraprofessional peer counselors are able to have a positive influence on clients' efficacy expectations, motivational states, and, ultimately, behavior (Olds, Kitzman, Cole, & Robinson, 1997; Sherman, Sanders, & Yearde, 1998). Self-efficacy refers to an individual's belief in her ability to accomplish the behaviors required to produce desired outcomes (Bandura, 1977). An individual's expectations about self-efficacy are influenced most powerfully by her own history of accomplishment, and by other sources of information such as verbal persuasion, vicarious experiences, and emotional arousal (Bandura, 1977). Paraprofessional advocates can have a positive effect on clients' self-efficacy by doing the following:

1. providing concrete, practical opportunities to accomplish goals of abstinence, recovery, and social adjustment;
2. helping clients recognize and celebrate each step toward performance achievements;
3. offering ongoing verbal and emotional encouragement regardless of temporary setbacks or relapses;
4. pragmatic role-modeling, as someone whose personal history is at least partially shared with the client, and who has achieved personal goals similar to those toward which the client may be aiming; and
5. helping clients learn daily coping strategies, including compliance with mental health recommendations and medication regimens, in order to avoid negative emotional mood states.

In exit interviews from the program, clients reaffirmed the validity of PCAP's theoretical constructs as they described how their advocates helped them believe in themselves:

> *She has taught me how to stand on my own two feet, and how to believe in myself.* — PCAP client

> *She helped me establish goals; she's helped me achieve my goals. She's taught me responsibility, dependability. After 3 years of working with her, I see myself as a strong, independent woman.* — PCAP client

> *This program really helped me think about my life. They showed me the right direction. They showed me that I am responsible. That no matter who I am or what I do, I am somebody. It is never too late.* — PCAP client

Clients also spoke to the critical role of the advocate as role model:

> *My advocate handled a lot of situations, and I learned through her how to deal with and talk to people.* — PCAP client

> *My advocate had a big influence on me and how I deal with things in my life.* — PCAP client

The Advocate, the Client, and the Client's Provider Network

In many intervention models, paraprofessionals work in teams with professionals within the same program. This structure implies a hierarchy and carries the potential for conflict and competition. In PCAP, advocates connect clients with a variety of experts in the community. At the beginning of their relationship, the advocate helps the client identify her own problems and goals (Grant, Ernst, McAuliff, & Streissguth, 1997). The advocate then identifies the community providers with whom the client may be even minimally involved (most of whom are not aware of each other's involvement). Next, the advocate locates appropriate providers to address unmet needs. In our experience, a community team approach is often touted but infrequently practiced, except in crisis situations. No professional provider has the role of convener, or the time to convene the people working with a client. Nor do agencies have the personnel and resources with which to help disadvantaged mothers manage the everyday problems they encounter through the unpredictable process of recovery from dependence on alcohol and drugs.

A PCAP advocate does these things. With, if necessary, the clinical supervisor's guidance and participation, and after releases of information are signed, she arranges meetings or conference calls to bring members of a client's provider network together, with the client present, if possible. Our clients typically have little self-esteem and poor negotiating skills. The advocate models phone and interpersonal behavior that is likely to elicit support and help. She helps the client organize her thoughts and articulate her concerns and goals. The advocate functions as a liaison for communication within the

client's provider network. She works to facilitate development of a service plan that addresses providers' concerns but does not create unrealistic expectations. The advocate then helps her client follow through with the plan.

In practical terms, the PCAP model means that a mother in recovery will not be faced with trying to comply with the Child Protective Services stipulation that she attend outpatient treatment 5 mornings a week in one part of town, while the probation officer requires urine screening twice a week elsewhere, and the housing authority assigns her to a low-income unit in a neighborhood that will require her to make 2 bus transfers to get to these destinations with her 3 children in tow (a true scenario). When providers communicate and recognize the realities of a family's circumstances, they can design a plan that will help a mother succeed in her recovery, rather than set her up for another failure.

Their own struggles and successes enable PCAP advocates to be positive and credible role models, offering their clients hope and motivation grounded in reality.

Professional and agency effectiveness increase when a paraprofessional advocate facilitates provider interaction and tackles the barriers (e.g., lack of housing, transportation, and/or child care) that could otherwise hinder or defeat a service provider's aims for a client. A primary care physician, for example, can focus fully on a family's health care needs when a paraprofessional who understands and can operate within the high-risk setting in which her clients live is addressing environmental issues. The skills that professionals and paraprofessionals bring to the intervention are distinctly different, but they are complementary (see, for example, Berlin, O'Neal, & Brooks-Gunn, 1998).

The Advocates

PCAP advocates have all experienced some share of the same adverse life circumstances as their clients, although seldom to the same extreme degree. Each advocate has faced at least 1 significant obstacle to well-being such as domestic violence, poverty, single parenting, an alcoholic parent, or personal alcohol or drug abuse. More importantly, each advocate has overcome the obstacle and achieved significant success: for example, by going back to school, or maintaining steady and meaningful employment. Their own struggles and successes enable PCAP advocates to be positive and credible role models, offering their clients hope and motivation grounded in reality. For example, of the 24 current PCAP advocates, 15 formerly used or abused alcohol or drugs, but all had been clean and sober for at least 6 years at the time they were hired. Nine of the present advocates are completing undergraduate or master's degree programs.

PCAP requires more of its advocates than most programs that use paraprofessionals. In order to be hired by PCAP, women must have at least 4 years of prior community-based experience related to prenatal substance abuse or associated problems, or the equivalent combination of education and experience. Some current PCAP advocates had worked, for example, in direct case management or outreach for youth, outpatient mental patients, families at risk of child abuse and neglect, women in prison-release programs, or medically underserved populations. Others had provided maternity support services or counseling in outpatient domestic violence or chemical dependency settings. One advocate had been a housemother for adults with developmental disabilities; another had been a cook in a women's substance abuse treatment facility.

Advocates explain how their experience helps clients:

> *I've lived through the things they've been through, so I'm not afraid or intimidated. I've lived with domestic violence. For someone to tell a client in a domestic violence situation to just up and go, it's not that easy. There are lots of plans to think about. I understand when someone says, "I can't just leave right now." But I can help plan a strategy, because I've lived it.* — PCAP advocate

> *I know what it's like to be a single parent, homeless, and on welfare. I share a common ground with my clients as far as those things go. The difference is that I saw what the obstacles were, and overcame them. I just kept moving ahead and learned that where there's a will, there's a way.* — PCAP advocate

> *I do* [this work] *in large part because I am the biological mother of a fetal alcohol effect son. I am a recovering alcoholic. I'd like to be part of the process by which other women can make changes in their lives, and prevent more of these kids from being born. I really do love my job. There are a lot of rewards. Women do get their lives turned around, and I know that when a woman gets her life turned around, it affects everybody in the circle of her life. So, we're breaking a lifecycle for these kids. These kids are not going to have to grow up and do exactly what their mothers are doing, who are generally doing exactly what their mothers did.* — PCAP advocate

Although PCAP advocates can identify with their clients and share some similar experiences, some take exception to the term "paraprofessional." They do not like the implication that they are peer counselors, but rather view themselves (as do other community providers) as experts in outreach and case management. As one PCAP clinical supervisor observes:

> *It's not the word "paraprofessional" that bothers advocates, it's the shared history part...they haven't ever been, except*

for the rare exception, as impaired as the clients we serve. A better way of saying it would be that the advocates have some aspects of their past which are similar to the clients' struggles. For example, many used but did not abuse drugs. Most were able to stop without treatment, and those who did go to treatment were successful the first time. This is a very different profile than the clients'. However, what is valuable is that our advocates can share their struggles and their solutions, and that is one reason why the program works.

Since PCAP began in 1991, a total of 39 advocates have been hired at 4 sites. Among the 15 advocates who are no longer with the program, 6 advanced to better positions after an average of 4.5 years. Two of the 6 earned MSW degrees during their tenure as PCAP advocates. Two other advocates left after several years because of medical problems. Seven left the position less than a year after beginning because of an obviously poor job fit, attributable to a range of factors — for example, difficulty fitting into a work culture; too little time in recovery and residual lifestyle complications; feeling intimidated by clients; and preference for a desk job.

Experienced advocates observe that sometimes their own efficiency can collide with the goal of helping clients achieve healthy independence.

Training and Supervision of Advocates

Comprehensive training is essential to a successful paraprofessional program. PCAP advocates receive 3 types of training:

1. initial 80-hour intensive training from administrative staff on program protocols and working with clients;
2. formal training sessions conducted periodically by professionals on specific issues that advocates encounter; and
3. ongoing training opportunities with representatives from community agencies (e.g., Planned Parenthood) who educate advocates about their agencies and how to work more effectively with them. (See Grant, Ernst, & Streissguth, 1999, for a detailed description of PCAP advocate hiring and training practices.)

PCAP clinical supervisors note that challenges can and do arise in managing a paraprofessional staff. Advocates may overstep boundaries by giving advice outside their areas of expertise, or by taking on roles and responsibilities for which they are not trained. Staff have at times become overzealous in their advocacy role, developing unwarranted confidence in a client's capabilities; when this happens, advocates may lose credibility with other providers. Experienced advocates have noted that sometimes their own task-oriented efficiency can collide with the model's goal of helping women achieve healthy independence within the context of a supportive mentoring relationship. Two types of scenarios are common. In the first, an advocate may become frustrated with a struggling client and do the work the client should be learning to do for herself, instead of guiding her in a process that will result in the client developing competence and self-confidence. In the second, an advocate may be tempted to leave a more competent client to her own devices, failing to remember the importance of a stable, supportive relationship in empowering the woman to achieve goals beyond the mundane.

The PCAP administrative–supervisory structure is designed to address issues inherent in working with a paraprofessional staff, while at the same time creating a rewarding work environment. Advocates note that the opportunity to undertake difficult challenges, work creatively, and "think outside of the box" is fundamental to their job satisfaction.

I like this work because I like challenges. In this project, I've been able to make independent decisions and be creative, and that's important to me. I have a vision of how it can be. I believe in miracles because I've seen it happen. This is what has spurred me on and given me the drive to work with these women even when I wanted to quit. — PCAP advocate

Working in this position has helped me grow as a person. I'm constantly learning new things. — PCAP advocate

Advocates describe 3 administrative components of the PCAP model that ensure job satisfaction and retention: weekly group staffing; individual, weekly supervision; and receiving feedback on client success over time.

Weekly group staffing meetings at each PCAP site are brainstorming, problem-solving sessions intended to leave participants in a positive frame of mind for the challenges they face during the week.

I look forward to the staff meetings, particularly when I'm stuck on a particular client. I need a lot of positive reinforcement and I get a lot of that at the staff meetings. — PCAP advocate

As the clinical supervisor discusses the status of cases in individual supervision with advocates throughout the week, she listens for common themes, problems, or service barriers that should be addressed in a group discussion; she may ask advocates to staff specific clients or situations at the next group meeting.

We each staff a client each week, so that gives us a chance to know about other people's clients, how they're doing, to get feedback from the other advocates and from the supervisor about problems that I might be having with a client that I need some fresh views on. Very, very helpful. It's just essential. If we didn't do it once a week I think we'd fall apart. — PCAP advocate

Advocates may present particularly problematic or unique scenarios to get feedback from colleagues, or they may describe successful strategies and situations resolved. As advocates listen, they learn from each other, provide ideas and support, and reflect on experiences with their own clients. At subsequent staff meetings, they give updates on client status and how suggestions have worked. A continuing challenge supervisors face is maintaining a balance between spontaneity (keeping meetings flexible and interesting) and structure (they are required to limit the meetings to 2 hours, yet cover project business and hear from each advocate within the time allotted).

Advocates sometimes voice frustrations or grief during this time together, and supervisors use these expressions as springboards for developing responses that can sustain staff. For example, at a staff meeting at her home, one supervisor asked her staff to write their frustrations and regrets on small cards, which they ceremoniously burned. They then wrote their aspirations on balloons and released them. In the ensuing discussion about common goals, they identified the importance of self-care, and subsequently have been better able to role model self care for their clients.

Individual supervision occurs weekly when clinical supervisors meet individually with advocates at a designated time for a minimum of 1 hour. Supervisors are available for consultation throughout the week either by phone or in person.

> *Individual supervision is so important because so often you get bogged down with the details of what you're doing, and the supervisor can give you a broader perspective of what you're doing. She can come in with some ideas that maybe you're weren't thinking of at the time and some different avenues you might pursue. Sometimes she'll even tell you, "Why don't you back off? You've been doing what you can, and not getting anywhere — back off, and let the client call you."* — PCAP advocate

Advocates are trained in data collection methods to assure quality control, and they record information monthly and semi-annually to track client progress.

The supervisor acts as an administrator, teacher, and mentor. She reviews advocate paperwork and case notes, discusses each client's status and how the case activities are related to client goals, and makes recommendations. If the advocate appears overwhelmed, she discusses how her work can be redirected toward the bigger picture and away from the small crises that the client might be able to handle herself. She periodically discusses areas of growth the advocate would like to explore for herself and opportunities for additional training.

Feedback on client success, embedded in PCAP's evaluation process, creates a dynamic feedback loop among evaluators, supervisors, and advocates that allows them to look at the data and see that they are indeed helping clients make gains, as well as to observe areas for improvement. The process recognizes that from a day-to-day perspective it is sometimes difficult for advocates to see that they are having an effect on clients' lives.

> *I feel really great when I see a client change, when we were here at this point, and now slowly but surely, we're getting to that point. It's just so satisfying to see that the work that we do, and that this program does, is actually effecting change in someone's life.* — PCAP advocate

> *I just get so much from seeing change occur. People say, "You've got to break the cycle -- you've got to break the cycle." People talk about it but they don't want to break themselves outside of the molds and the boxes to make it happen. We're able to do that here. We're seeing it happen and it works.* -- PCAP advocate

Advocates are trained in data collection methods to assure quality control, and they record information monthly and semi-annually to track client progress. Client outcomes and advocate job performance are clearly separated. The program evaluator reports to the PCAP staff every 6 months on outcomes among clients who have graduated from the program and among those currently enrolled. Advocates and supervisors discuss notable areas of progress as well as areas in which desired outcomes are not being achieved so that solutions can be developed as quickly as problems are observed. While paperwork may not be a favorite part of the job, this feedback helps advocates better understand their work, and they are empowered by active participation in the evaluation process.

Examining the PCAP Process

Is the PCAP intervention as conceptualized in theory what the families actually receive? We have used 2 assessment instruments that attempt to "open the black box" and answer this question (see *Zero to Three*, February/March 1998).

The PCAP model holds that the relationship between advocate and client is central to the success of the intervention, because it is the path through which change occurs. As a quantitative proxy measure for the extent of relationship, advocates document the amount of time they spend with clients each week using the Advocate Time Summary Sheet. Recent findings indicate that among 146 clients who completed the program, advocates and clients spent an average of 64.2 (SE = 4.0) minutes per week together over the 3-year intervention. In general, clients who spent more time engaged in the relationship with their advocates (> 90 minutes per week on average) were more likely to achieve positive outcomes than those who spent less time (< 30 minutes

per week on average). They were more likely to: 1) complete inpatient treatment (86% versus 39%, respectively); 2) abstain from alcohol and drugs for at least 1 year at exit from PCAP (44% versus 36%); and 3) use a reliable form of birth control such as Depo Provera injections or tubal ligation (53% versus 45%). Thirty-eight women had a subsequent birth during the program; babies born to women who spent more time with their advocates were less likely to be exposed to alcohol or drugs *in utero* (33% versus 55%). These findings concur with outcomes in the original demonstration project (Ernst et al., 1999).

When clients leave PCAP, we ask each to report on the quality of her relationship with her advocate using the Advocate–Client Relationship Inventory, a 27-item questionnaire adapted from an instrument developed for the Memphis New Mothers Project (Barnard, 1998). Among 146 PCAP clients who completed the Inventory, 85% agreed or strongly agreed with 16 items:

- Half of these fell within the "caring" construct (as conceptualized by Barnard): Clients viewed their advocates as emotionally involved, present, doing for, enabling, and giving hope. These items reflect PCAP's relationship framework.
- Four of the top items were in the "coaching" construct: Clients viewed their advocates in a supportive role, as a coach who helps a woman reach her potential.
- Four items were in the "ongoing developmental" construct: Clients viewed their advocates as assisting them with the developmental issues of a mother in her various roles.

These coaching and ongoing developmental constructs are analogous to the stages of change and self-efficacy philosophy incorporated by PCAP.

None of the top 16 items was in the "harmony" category (harmony among the mother, her family, and the intervener). This was not surprising: PCAP advocates help clients make major changes in dysfunctional behaviors, a role that may create disruption in dysfunctional family patterns.

Conclusion

What is it that makes the PCAP paraprofessional model work? We attribute PCAP's success to a number of characteristics that may distinguish it from other paraprofessional programs. PCAP paraprofessionals are hired at a high standard. While they have some history in common with their clients, they are able to form enduring and healthy relationships with their clients because they have accrued the time and the achievements that confer a level of emotional objectivity and competency. This type of perspective allows for a relationship that is more therapeutic than sympathetic, more professional than peer. Other PCAP hallmarks that account for program success include excellent, ongoing training and close supervision; the recognition that comes with opportunities for advocates to give community presentations about their work; and the sense of pride that comes with being affiliated with a successful, university-based project.

The Parent–Child Assistance Program is a focused, theoretically-based intervention for the highest risk mothers in the community. Within the context of a relational model that enhances the mothers' ability to change, it provides a framework in which carefully selected, trained, and supervised paraprofessional advocates work. Advocates link mothers with community providers as needed, and support them as they grow and change in order to prevent another cycle of hopelessness and deprivation.

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THE HELPING RELATIONSHIP IN A TEEN PARENTING PROGRAM

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When parents with young children enter a support program, what are they really hoping to get out of it? What motivates a family to seek out services, to engage with a program, to form a relationship with staff? And if parents feel supported by program staff, is that going to make a difference in the life of their child?

Early childhood interventions now often emphasize the importance of attending to relationships, both within families (such as between parent and child, or between adult family members) and between families and service providers (Emde, Korfmacher, & Kubicek, 2000). The principles of infant mental health are increasingly being integrated into the practices of community programs through the language of relationships: Recognizing that "how you are is as important as what you do" (Pawl & St. John, 1998) and being "someone who listens and really cares" (Pharis & Levin, 1991) are now considered crucial elements of intervention.

This project was funded with support from the Spencer Foundation. The data presented, the statements made, and the views expressed are solely the responsibility of the authors. We would like to thank Suzanne Steinrueck, who assisted in the development of the interview coding system, and the staff at the program sites where the study took place, who were generous with their time and open to discussing challenging issues in their work.

While we know, in general, that the helping relationship is important in infant/family work, we still have much to learn about the details. Early childhood intervention often borrows from fields such as psychotherapy or nursing for models of the helping relationship. Yet there is currently no consensus across disciplines or among intervention models on how best to describe the helping relationship. A *prevention* or *family support program*, for example, may view the helping relationship in terms of support and guidance. The

at a glance

- In a program for pregnant and parenting teens in Chicago, many paraprofessional advocates and clients viewed their relationships as "personal," which led them to take setbacks personally.
- Logistics and scheduling often affected the success of advocate–client relationships, as did client load and inadequate supervision.
- Mothers viewed a frequent staff turnover and a lack of confidentiality, attention, or "helpful" knowledge as detrimental to their relationships with advocates.
- Clients confronting advocates with these concerns improved some relationships.

service provider's friendly, warm presence, combined with the information provided to the parent, promotes empowerment and positive development in parent and family functioning (see Halpern, 1999). A positive relationship is important because without it parents are unlikely to listen to or trust the helper enough to accept guidance and support. *Psychotherapeutic interventions*, on the other hand, are designed to help the parent work through emotional barriers to a satisfying parent–child relationship. Feelings and memories of a difficult childhood may, for example, interfere with a parent's ability to respond to a baby's needs (e.g., Lieberman, 1991). In this intervention approach, the treatment alliance is therapeutic as well as supportive and informational. The relationship itself is an opportunity for a corrective emotional experience.

Without a positive relationship, parents are unlikely to listen to or trust the helper enough to accept guidance and support.

How we conceptualize the helping relationship should guide how we think about the experience, training, and ongoing support staff members needed in order to connect effectively with families. Is the helping relationship an element of intervention that is largely intuitive? Or do forming and keeping alliances require deep reflection and careful consideration of strategies? Is it enough to be open, friendly, and supportive? Or does the practitioner need to keep a delicate balance of empathy and objective distance, walking the narrowly appropriate path of engagement?

These questions are especially important to consider in relation to paraprofessional staff in early childhood programs, who lack formal service training. Unlike psychotherapists, nurses, or social workers, they have not had a professional educational experience that includes closely supervised opportunities to develop specific skills of relationship-building. Instead, paraprofessionals are familiar to program families by dint of shared history or social characteristics; do not have formal titles or degrees that remove them from families; and can develop "real" relationships that are relatively unencumbered by power differentials (see Korfmacher & Hans, this issue).

Studying the Helping Relationship

Examining how helping relationships are viewed and experienced across early childhood intervention models and service providers is no easy task. To date, studies of the helping relationship in early childhood programs have been done in a fairly cursory fashion. For example, investigators use scores from rating scales on factors such as "parent engagement" to characterize an entire relationship. Yet we know that relationships can ebb and flow over time, and that a client and service provider may characterize their relationship differently (see Roggman, Boyce, Cook, & Jump, 2001, for an example). Used in isolation, rating scales do not provide a language or a deeper understanding of the issues involved in developing alliances with families, and they do little to inform program practice.

For these reasons, we have undertaken an exploratory study of the helping relationship across different early childhood intervention program models, examining in depth a small number of carefully selected relationships. We interviewed both clients and providers to get a sense of differences in perspective, and we collected information across multiple interviews to see how relationships changed over time. We used a qualitative approach so that we could explore important themes that emerged during the interviews in greater detail and capture the language that providers and families used when talking about how they spend time with each other.

In this article, we will use examples from a paraprofessional home visiting program to highlight the distinct issues that these helpers face in forming alliances (at other sites, service providers are infant mental health therapists or doulas). The primary source of data is semi-structured interviews that we conducted with service providers and clients in their caseload 3 times over the course of a year (participants also used self-report rating scales, although these will not be used in this paper). The interviews focused on several issues related to the helping relationship between provider and client, including:

1) the client's motivation for joining the program;
2) her description of the relationship and how it changed over time;
3) similarities and differences that the client and provider see in each other;
4) the provider's involvement with other family members in the program;
5) how conflicts and disagreements are handled; and
6) how the client and the provider view the provider's helpfulness to the client.

These interviews were tape recorded and transcribed, then subjected to content analysis (see Patton, 1987). We developed and refined a coding system based on themes and patterns that emerged from the interviews. Each of us reviewed transcripts individually, arriving at consensus in regular meetings and discussions.

The Context of Our Study

A network of programs for pregnant and parenting teens exists within Chicago's public high schools. Young women are enrolled in the program during pregnancy or at the birth of their child, and families can remain in the program until the child is 3 years old. The program model has 3 areas of focus: 1) school attendance and high school completion; 2) prevention of repeat pregnancies; and 3) parenting and the promotion of infant learning and development. Family advocates, paraprofessional women who live in the community in which the high school is located, work directly with the

young women. Advocates use specific protocols during home visits to promote infant learning and development, but they are allowed to be flexible in order to address the individual concerns of a mother.

In this program model, weekly visits are the goal. Much of the contact between the advocate and young mother occurs at the school, either informally, in the advocate's office, or in weekly group meetings. Advocates make home visits during the day to the young child, who is often with a grandmother or other family member. During the period of our study, the citywide program had a limited number of supervisors, who were responsible for overseeing multiple sites during a rapid expansion of the program. Because of administrative demands on their time, they gave senior advocates much of the responsibility for direct supervision of advocates' visit activity at each site.

Eleven young mothers and 3 family advocates from 2 schools participated in our study. The advocates served from 8 to 18 families each. We invited family advocates to participate in the interviews if they had a large enough caseload from which to choose appropriate clients. Initially, we planned to interview 2 family advocates at each site and 3 young mothers from each of the advocate's caseloads. However, given staff turnover at one site, we were able to interview only 3 advocates and 11 mothers. (This turnover became an important part of the study.) The first author worked with each advocate to select clients from her caseload to invite to participate in the study. We asked advocates to select at least 1 client with whom they felt a strong alliance and 1 client who presented challenges. Reflecting the ethnic composition of the high school and surrounding community, family advocates and clients at the first school (which we will call Wellington) were African American. The advocate at the second school (which we will call Harrison) was Latina, as were most of her clients.

Themes Emerging From the Interviews

The personal relationship. The strongest theme that emerged from the interviews is that both family advocates and young mothers conceived of the helping relationship in very personal terms, with the family advocate often assuming the role of a mother figure, family member, or friend. Family advocates used such terms when describing their relationship with 10 out of 11 young mothers. If family advocates felt they had a positive relationship, they would talk of a comfortable familiarity when discussing the client, as this quote demonstrates:

> *I can go and I can sit back and you know, I can sit back and we can just talk. And then sometimes after we find ourselves on a totally different subject. And I'm like, "Oh, girlfriend, you be doing my part and get over here so we could do this." So it's like so comfortable and relaxing. So the times spent with her it's like I could sit and hang with* [her].

The young mothers, too, use personal terms when discussing their family advocate. Nine out of 11 clients used family member or friend terms to describe their family advocate. Although this was not always positive (one mother noted about her advocate, "You know how grandmas like to lecture you?"), in general they appreciated this closeness:

> *She just took me in just like…I feel like she's a second mama; I'm like a second daughter to her. She'll call me. She'll say everything: "Girl, guess what happened?" I say, "What happened, mama?" We just talk.*

Viewing each other in these roles, however, was not limited to times when the alliance was strong and trusting. This personal orientation also existed in problematic relationships. Family advocates would note their disappointment in some young mothers, conveying the sense that the mother had let them down personally when she had difficulties in parenting or continuing her education. One family advocate said:

> *I know I did what I was supposed to have did. I did the home visits, and I had started the activities with the baby…When she had the baby, I went out to the hospital to visit her…so I did my part. But it's just that she didn't do hers. She didn't keep up with her part.*

Another told us:

> *It really hurt me that she wasn't back in school. Because I felt like our relationship was much better than that…*[In] *the beginning, I was happy to know she was my client. She was the happy client. And now, I just get frustrated because she's not in school, she's not working. She's getting lazy. And it really pisses me off actually, you know? Because it seems likes she's going backwards when she needs to be going forward.*

Although the young mothers rarely expressed active disappointment, they did report drawbacks to their personal relationships with their advocates. Mothers noted 3 difficulties. First, there was the lack of confidentiality resulting from the relatively loose boundaries of the relationship. Some mothers said that family advocates would share stories with each other about their clients. Second, some clients felt that their family advocates took them for granted and did not visit them or their children as often as they should. Third, even if a mother viewed her advocate as friendly, she did not always describe the advocate as helpful. One young mother described her advocate and their regular visits in positive terms, but said that what her family advocate talked to her about, she "already knew."

Conflict and confrontation. Handling conflict emerged as a related theme in the interviews. The family advocates struggled with how to deal with disagreements between themselves and the mothers. They would often ignore or

avoid conflicts in order to maintain friendly relations with the mother:

> *She always ask me, "Why you don't give me no opinion?" "Because for one reason. If I give you an opinion and it's wrong, then you're gonna dislike me because you're gonna say, '[She] gave me the wrong opinion.'"*

Advocates disagreed to the extent that they could address conflicting or controversial issues in their clients' lives. Although advocates at one site felt relatively free to talk to mothers about elements of their personal lives (for example, boyfriends or birth control), the advocate at the other site was wary of broaching these issues:

> *I ask her how* [her boyfriend] *doing, how are things with you, and she says, "It's okay," but we don't get deep into her life.*

Advocates became directive or confrontational with a mother most when they were angry or disappointed. Sometimes angry family advocates wanted to cut off contact with a mother altogether:

> *I just tell her, "I'm just gonna block you out!" And that's the way things going with me and her. Until she really gets herself back into school, I think me and her gonna be like that.*

Contextual factors. Logistical and environmental factors affected the relationships between family advocates and young mothers. Advocates were expected to assist the mother in staying in school until graduation *and* to provide an infant learning and development curriculum. Since advocates only worked part time, during school hours, they seldom had a chance to work with mothers and infants together. Having to make 2 contacts each week (1 with the mother, 1 with the child) increased the advocates' workload and led to compromises -- for example, not visiting the child as often as the mother would like, or relying on a brief "check-in" with mothers at school. This situation added to the complexity of each advocate's job, as she sought access both to the mother and the child's daytime caregiver, usually another family member.[1]

The physical setting of the 2 program sites also had an influence on relationship formation. Both sites encouraged mothers to come by the program offices at the schools to check in or ask questions. The office at Wellington was roomy enough for mothers to feel comfortable "hanging out" there during lunch or breaks. The Harrison office, in contrast, was smaller and used by school personnel who were not part of the program. Mothers could not spend much time there. Moreover, the Harrison office did not have a phone, which made non-scheduled contact between advocates and clients difficult. Given these factors, we were not surprised to find much more informal contact between mothers and advocates at Wellington, while Harrison mothers and their advocates saw each other largely at formally scheduled group meetings.

Staff turnover. The biggest difference between the two sites was the level of staff turnover at Harrison. The young mothers at this site expressed frustration with frequent changes in advocates, and were wary of the program and its ability to help them. Although they still hoped to use the program for specific purposes (such as getting information about child care subsidies or obtaining a school ID number for their child), interviews with the mothers suggested that they felt ambivalent about connecting emotionally with new family advocates. Frequent staff changes meant that we were unable to appropriately assess an unvarying cluster of relationships between young mothers and family advocates over time. Nevertheless, the turnover did give us a sense that the relationship has a special place within the functioning of the program, a place made even more apparent by its absence. One young mother made the point quite poignantly:

> *Well, it's not* hard *to get close, I mean I don't* want *to. Because then you get close and then they leave, or they get fired or something happens...They're just different people all the time, and that's not good. 'Cause how are you supposed to talk to someone who you don't even know?*

How Did the Relationships Change Over Time?

On the basis of our first interviews with young mothers and family advocates, we labeled 8 of the 11 relationships as positive and 3 as ambivalent. In 2 ambivalent relationships, the family advocate reported a very positive alliance, but the mother used negative language to describe the relationship. In the third ambivalent relationship, the mother could not initially figure out which of 2 family advocates was the one assigned to her.[2] Since our study design allowed us to conduct 3 interviews with family advocates and mothers over the course of a year, we were able to further categorize relationships as those that remained positive and those that became more negative. (At the site with staff turnover, we categorized based on a client's comments about her current family advocate at the time of the interview.)

In general, relationships between young mothers and family advocates became more negative over time. Of the 8 initially positive relationships, only 2 remained positive over the course of the year. Four became ambivalent, and 2 we classified as negative by the third interview (1 from each site). Two of the 3 relationships initially coded as ambivalent (1 from each school) were categorized as negative by the third interview.

1 Since the time of our interviews, the program has instituted on-site child care at some of the schools, which might alleviate some of these difficulties.

2 The mother's general attitude towards the advocates was positive but muted. For this reason, we decided not to characterize this relationship as negative.

We considered the possibility that the negative shifts were due to an increased comfort with reporting difficult aspects of the relationship. As the participants became more familiar with the interviewers, they may have felt less of a need to present the relationship in overly positive terms. But our review of the transcripts suggests that the participants themselves were surprised by the changes in the relationship. One advocate noted that she had thought the 3 clients that were the focus of her interviews were her most promising, and did not expect to have so many challenges with 2 of them. Statements from the young mothers also suggest the difficulty of maintaining these relationships over time. One mother became increasingly resistant to seeking out support from her advocate, telling us that "sometimes when you ask some people for help so many times, they think you always need them for help."

In one relationship, which we view as instructive, we saw a different pattern: This alliance was initially ambivalent, but it became positive by the final interview. During the first interview, we asked the young mother why she decided to join the program:

> *I don't know. This what I was asking* [the advocate] *like, "What do this program give us?" 'Cause I don't see what they give us…Like I know a program that helps, you know, they give out…Pampers and stuff like that. We don't get nothing. I don't know.*

The mother in the course of this interview also mentioned that her advocate would "lecture" her, but overlooked visits with her child. It seemed as if she were unsure of the value of spending time with her advocate, but wanted her and her child to have this time nonetheless. In an interview not quite a year later, however, this mother's devotion to her advocate was clear:

> [She] *ran my case a lot, like "Do right," "Go to class," and now she don't have to tell me to do that because I know that these are things that I want to do for myself. I want to get into a good school, make something out of my life, you know. And she just motivates me now. You know, it's not like she's preaching to me all the time; she's praising me, motivating me, 'cause I'm doing good. I'm waiting to get accepted into college, and* [she] *was just proud of me for all that…I don't want nobody else to work with me and my child but* [her].

What brought about this change? Both mother and advocate noted that the young mother confronted her advocate about the amount of visiting she and her child were receiving. The advocate realized that this was a problem and began making more of an effort to keep a regular visitation schedule. The process of working out this conflict with the family advocate seems to have made the relationship more positive and trusting. It is interesting to note that the change occurred because of the mother's initiative. Perhaps some advocates had an easier time supporting and building on mothers' strengths, even if strength was expressed as a challenge to the relationship.

Implications for Programs

We must be cautious when making any generalizations from such a small sample of participants. The benefit of using rich and in-depth information needs to be balanced against the limited sources for this information. It is possible that the configuration of advocates and young mothers we interviewed was unusual, with a bias toward challenging relationships fated to deteriorate over time. We cannot say that the experiences that the participants described are typical for them, this program, or of paraprofessional programs in general.

On the other hand, previous studies show that maintaining positive relationships over time can be difficult in programs that serve at-risk adolescent parents (see Osofsky, Culp, & Ware, 1988, for another example). Teen mothers can face enormous difficulties and stressful circumstances while trying to juggle school, work, and parenting at a young age. Effecting positive change in the lives of young mothers requires special knowledge, skills, and attentiveness. The interviews we conducted highlight these challenges.

How important is the relationship between paraprofessional helpers and clients? We began our study assuming that the relationship was central to the intervention model — that is, the strength and quality of the relationship determine whether the participants want to stay involved in the program and the meaning they attach to their participation. Our first set of interviews challenged these assumptions. Even when we asked the participants specifically about the relationship, both young mothers and advocates could be fairly dismissive of its importance and function. Some mothers seemed to see advocates as interchangeable. Young mothers often talked to more than one advocate. Advocates would share stories about mothers among themselves. If an advocate left the program, both mothers and advocates seemed to feel that any of the other advocates could step in and take the original advocate's place (at one site, this was a rationale given by advocates for sharing information about clients with each other so freely).

As we read the transcripts of our first set of interviews more closely, we recognized signs of the shared emotional meaning that characterizes a strong relationship. Although mothers did not want to be seen as needing "help," they would get upset if they felt their advocate was being inattentive. And all but one mother at Harrison, with its high rate of staff turnover, became less engaged in the program as advocates rotated through.

Most striking, the emotional intensity of the mother–advocate relationship, especially as expressed by the advocates, seemed to both help and hinder the advocates' and mothers' ability to work together. Advocates were extremely enthusiastic about their time with their clients

when things were running smoothly. But they were deeply pained when their clients went "off track"; in essence, the advocates felt as though the clients had let them down.

To Listen and To Care

In the opening paragraphs of this article, we quoted Pharis and Levin's observation (1991) that the most important role for a helper of high-risk mothers is to be someone who listens and really cares. But what does "to listen and to care" mean? We do not suggest on the basis of this study that advocates should completely *avoid* having personal relationships with young mothers. Mothers and advocates expressed many positive feelings toward each other in the interviews, and it appears that the willingness of the advocates to show such interest in the young mothers is important in connecting them to the program. However, if advocates wish to have a personal role in the relationship and to manage it over time, then they need to know how to do so in a way that works.

Without specific training and ongoing support, it is very easy to respond to client cues in a way that complements the client's own expectations about people and about receiving help. For families in prevention programs who can readily engage in working alliances, this is not a problem: The client's motivation motivates the helper. But with clients who have difficulty forming meaningful relationships, who are ambivalent about seeking help, or who struggle with keeping a relationship on a positive trajectory, the work is considerably harder.

Paraprofessionals are not psychotherapists or nurses or social workers. They need to approach families in the way that makes sense for them. But there is a delicate balance between offering support and challenging old ways of relating when the goal is to promote healthy development in families who are at high risk. To do this well, especially during periods of crisis or distress, takes a great deal of reflection and strategy. How paraprofessionals (or, for that matter, any type of helper) do so while still retaining a sense of who they are — a genuineness of self — is the hub around which the relationship turns. To do well by these clients involves more than being available and reaching out in a general way. Helpers need to think actively about how to connect with each family.

At the same time, program leaders need think actively about how to help front-line staff connect with families. Supporting parents and their babies can be hard work. In our interviews, the advocates seemed to need support in order to connect with young mothers, stay connected over time, and handle their own feelings about these mothers and their relationships with them. The advocates needed assistance in setting boundaries with families and managing caseloads. They needed to recognize and deal with the constraints their offices' physical environments placed on their work with mothers. Like all helpers, the advocates needed opportunities to reflect on what it means to listen and care, to them and to the families they serve.

Providing paraprofessional helpers with the support they need in order to give meaningful help to high-risk families is a difficult process (see Musick & Stott, 2000). Programs who spread resources thin and serve many families with too few helpers will likely not be able to provide the supervision that assists front-line staff with their own professional identity and development. The advocates in the program we studied often, during informal conversations in the office, relied on each other for help (which, as noted above, raised issues of confidentiality for some young mothers). They had few chances to think through important issues with a supervisor.

But the potential for this type of reflective supervision is great (Gilkerson, 1995). In the final round of interviews, we asked advocates if the time they spent with each young mother caused them to think differently about themselves as helpers. This was a new question for the advocates, and they often did not know how to answer it. But the answer of one advocate, offered after discussing a particularly difficult time with a young mother, suggests both the challenges and the possibilities of these relationships:

> *I see things how I wanna see them and how I want them to go…So when something happens, it's like a setback…I just assume the way I want it, that's the way that they wanted it. So now, I have to learn to accept change. I have to learn that everybody is different…It changed me and let me see, "You are not always right." You have to learn from these kids too because they are trying to tell you something. You just aren't listening.*

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The Chicago Health Connection's Teen Peer Leader Program:

Helping Adolescent Mothers Tell the World About Breastfeeding

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Photo: Marilyn Nolt

Who might be able to persuade low-income adolescent mothers to breastfeed their babies, then support them when they choose to do so? Could this be a job for teen mothers who have successfully breastfed their own infants, and are now eager to tell the world about breastfeeding?

The Chicago Health Connection's Teen Peer Leader Program is currently implementing just such a strategy. The Chicago Health Connection (CHC) is a not-for-profit grassroots organization that has trained breastfeeding peer counselors under a community health worker model since 1986 (see sidebar, p. 29). CHC's Teen Peer Leader Program trains adolescent mothers who have expressed a willingness and enthusiasm to promote breastfeeding among their peers to use a variety of outreach activities in their communities. In a series of observations and conversations with the teens-in-training, I was able to see the vitality of the Teen Peer Leader Program, as well as some of the challenges facing the adolescent mothers and their mentors. This article discusses these 2 contrasting aspects.

Teens as Peer Counselors

Despite the many benefits of breastfeeding to mother and infant, adolescent mothers are rarely encouraged to breastfeed. Health care providers, for example, may

assume that completing her education may be a more long-term benefit to the adolescent and her infant than a few months of breastfeeding, if breastfeeding entails the risk that the mother may not continue her schooling (Reedy, 1991). Given adequate support, however, women, regardless of their demographic profile (in other words, including teens) will choose to breastfeed longer than they would without support, and they will breastfeed exclusively (Lazarov, 1994).

Who can provide appropriate breastfeeding support to teen mothers? As Stuart (1994) has noted, resilient adolescents provide an untapped resource for peer counseling programs. CHC had been developing programs targeted to teens since 1994, and in 1999 the agency sought funding to initiate a more intensive program, one that was designed to train energetic, enthusiastic adolescent breastfeeding advocates. More specifically, CHC planned to work with a culturally diverse group of low-income teen mothers who made the decision to breastfeed during pregnancy and subsequently went on to breastfeed successfully for periods ranging from weeks to several months.

The Teen Peer Leader Program aims to prepare teen mothers to promote the benefits of breastfeeding to their peers using a variety of outreach activities in their communities.

The Teen Peer Leader Program aims to prepare teen mothers to promote the benefits of breastfeeding to their peers using a variety of outreach activities in their communities. The program provides the participants with a chance to become actively involved in their communities and encourages them to develop authentic voices with which to contribute their expertise in the promotion of breastfeeding. Teen Peer Leaders are expected, under supervision, to promote breastfeeding in formal and informal presentations, provide individual and group support for breastfeeding, and follow up contacts with telephone calls. Leaders receive stipends for their outreach activities: They are paid $10 for each day of training and are further assisted with transportation and child care.

During 3 initial daylong training sessions, program facilitators provide guidance, support, and information about the importance of breastfeeding. Simultaneously, facilitators teach communication, presentation skills, and other aspects of leadership. The teens-in-training also have an opportunity to learn basic office and computer skills.

Following the initial training sessions, the teen leaders engage in various outreach activities and participate in an ongoing follow-up program designed to provide supervision for the young women in their role as peer counselors. The leaders are required to attend semi-monthly meetings under the direction of a program facilitator. The teens are encouraged to keep a log of their follow-up calls to their contacts and to describe how their community outreach activities are being carried out. Facilitators initiate discussions, urging the teens to share what outreach strategies are successful or, conversely, what roadblocks they encounter. Facilitators encourage the teen leaders to provide feedback and suggestions about the program itself, hoping in this way to empower these young women to create and accept ownership of a unique program that they helped to design.

The teens are recruited for training by word of mouth or referrals from the city's alternative schools and other programs targeted to inner-city pregnant and parenting teens. By breastfeeding their infants, recruits have already demonstrated resiliency in one important aspect of their lives. The challenge for the program, however, has been to recruit teen mothers who have not only breastfed their infants successfully, but who also possess the potential "to see beyond what others see" (Belenky, 1996, p. 425). The Teen Leader Program demands resilient participants (see Lewis, 1999) who see their success as inextricably connected to their personal efforts, and display attributes of persistence and optimism. CHC facilitators build on these qualities, nurturing young mothers in leadership training by creating a caring, supportive environment in which learning can take place. When recruiting and selecting program participants, staff must ask, Are these adolescents resilient enough to set goals and plan for the future? Do they have the capacity to become future community leaders?

Interviewing Teen Advocates

My interest in peer counseling developed several years ago during graduate school. I conducted a series of individual interviews with adult women who were in one of the first CHC peer counselor training programs. By listening to stories about their personal experiences, I hoped to discover the peer counselors' attitudes and perceptions about breastfeeding. What I heard was an overwhelming need for the peer counselors-in-training to "tell the world" about breastfeeding — in other words, to proselytize. These

at a glance

- Given adequate support, new mothers will choose to breastfeed longer than they would otherwise, and will breastfeed exclusively.
- Teen advocates in a Chicago program work to promote breastfeeding with their peers and "tell the world" about the benefits of breastfeeding.
- All the teens found working through the difficulties of breastfeeding empowering.
- In the program, teen leaders begin to see their lives and actions as having real meaning and significance.

women were so proud of what they had accomplished as breastfeeding mothers that they wanted to share their experience and knowledge with family, friends, and members of their communities, thus encouraging others to breastfeed (Locklin & Naber, 1993). Breastfeeding peer counselors bring a mission-driven commitment to their work (Abramson et al., 1993).

I followed up this initial study by interviewing a group of women who had been supported by breastfeeding peer counselors in order to understand their perspective on breastfeeding. These women were so grateful for the support and encouragement they had received that they, like the peer counselors, told me that if they had the chance, they would tell everyone how important it is to breastfeed their babies. They too felt the need to "tell the world" (Locklin, 1995). When CHC began its Teen Peer Leader Program, I naturally wanted to meet and interview the participants to discover this younger group's perspective on breastfeeding promotion. I assumed that these young mothers would also want to "tell the world" about their breastfeeding experiences.

I sought permission from the CHC Administrative Director and the group facilitators to sit in on Teen Peer Leader training sessions and discussion meetings in order to meet the young women, and requested permission to audiotape their conversations during the sessions. All agreed. I attended 1 scheduled daylong training session, then met the teen counselors-in-training again at 2 of their semi-monthly meetings. The meetings typically lasted about 2 hours. I hoped to gain information about the group's attitudes, perceptions, and knowledge about breastfeeding, as well as what it was like to function in the role of a teen peer leader. Incorporating the methodology of focus groups and participant observation gave me the opportunity to observe the teen mothers interact with their own young children (who always accompanied their mothers to the sessions) as well as to listen more thoughtfully to their words by replaying audiotapes of the sessions.

I interviewed 7 young women. All had been teen mothers, although 2 of the African American women were in their early 20s at the time of this study (the ages of mothers in the group ranged from 17 to 22). The young women were currently breastfeeding or had breastfed their infants for anywhere from 4 months to more than 18 months.

Resilience and Knowledge

At the first training session I observed, the young women made it clear that they "knew their stuff," detailing at length the many advantages of breastfeeding. These young women knew about breastfeeding from their personal experience, and training sessions had given them a more thorough understanding of the process. They were eager to share stories of their own experiences to reinforce the new information gathered at the training sessions. For example, one of the perceived barriers to breastfeeding for the adolescent is embarrassment (Martens, 2001). Yet these young women were not embarrassed about breastfeeding in public. One young woman said, "I feed him when he's hungry…I breastfeed on the bus." Another said, "Do you know that the security tried to put me out of the mall because I was breastfeeding…Can you imagine that?" To these teens, being denied the opportunity to breastfeed in public was absurd. One enthusiastic teen peer leader announced, "Breasts work! God put those things there for a reason."

When the facilitator introduced the topic of "getting started" with breastfeeding, personal stories dominated the conversation. Like older breastfeeding peer counselors I had listened to in my research, the teen mothers tended to

The Chicago Health Connection

Since 1986, the Chicago Health Connection (CHC), a not-for-profit, grassroots organization, has been actively involved in a community health worker training movement. Their mission emphasizes the training of paraprofessionals and peer counselors who will provide community-based outreach health promotion activities in medically underserved areas. CHC's educational approach is targeted to health promotion advocacy groups as well as health care organizations and individuals that share a dedication to women's health initiatives. CHC's program philosophy is the recognition that health care professionals must partner with community residents: Professionals share their practical knowledge and skills while recognizing and acknowledging that community residents also have skills that professionals can nurture.

CHC employs the Freirean model of empowerment education in training peer counselors. Paulo Freire (1973) envisioned the theoretical understanding of empowerment education as the essence of social justice and equity. The Freirean model requires the active participation of those becoming empowered. Individuals are encouraged to critically examine their own lives and behaviors through imaginative learning principles. Learning takes place in an atmosphere that encourages action toward change — in this instance, through promoting the specific health-promoting activity of breastfeeding. One goal of empowerment education is to enable individuals to gain some measure of power in their lives. Shields (1995) envisions empowerment for women as involving the emergence of self, a sense of connectedness, the use of intuition, the ability to take action, the ability to develop a competency, and, most important, the ability to speak out. In CHC training, peer counselors have the opportunity, through practice and reflection, to develop the skills that facilitate communication so that problems can be discussed, collegiality fostered, and support rendered.

describe the first days of breastfeeding as "hard." They were eager to tell their stories.

I was so tired at first.
I had sore nipples.
I leaked all over the place.
I couldn't relax in the beginning. It took me a long time.

The teens had advice to offer. When one young mother asked what others did to stop the leaking, other teens said that they had used sanitary napkins or tissues in their bras. Eventually, all agreed breastfeeding "gets easier."

Once breastfeeding became more firmly established, the teen mothers intuitively realized that they were accomplishing something important. Although she wanted to stop breastfeeding when her son was 5 months old, one young woman noted, "He won't take a bottle; he only wants me." Another mother observed, "I know [my baby] is crazy about me, because I breastfeed her." A third teen pointed to her 7-month-old son: "Look how healthy he is! Why would I stop?" Everyone agreed with her statement: "Weaning is the hardest part!"

The voices and words of these young women confirmed to me that they are capable problem-solvers — creative and persistent. Each one had persevered through the rough first days of breastfeeding her newborn and had continued to breastfeed for an extended length of time because the process was working. The teen leaders acknowledged the importance of encouragement from others. Each spoke of the social support she received from family, boyfriend, and health care provider, such as clinic- or hospital-based nurses. (Interestingly, these young mothers did not count on physicians for support for breastfeeding. As one teen was quick to point out, "No doctor told me or suggested to me to breastfeed, and now my doctor wants me to stop!")

Peer Counseling and Breastfeeding

Peer counseling is reaching out to peers to assist them with a problem by lending support. According to Stuart (1994), peer counseling involves more than reaching out informally; it requires systematic training in interpersonal communication skills and education about helping and caring. Tindall (1989) defines peer counseling as a variety of interpersonal helping behaviors assumed by nonprofessionals who undertake a helping role with others. The term "peer" denotes a person who shares related experiences, values, and lifestyle. Consequently, one of the strengths of peer counselor programs is that participants often share the ethnic background and cultural environment of the clients they serve.

Peer counseling has been recognized as an effective intervention in the promotion of breastfeeding among low-income women of color in the U.S. (Caulfield et al., 1998; Shaw & Kaczarowski, 1999; Bronner, Barber, & Miele, 2000). Peer counselors are used worldwide to provide the social and informational support that mothers need for the successful initiation and maintenance of breastfeeding (Morrow et al., 1999).

Vulnerability and Disclosure

In the sessions I attended, the facilitator would bring up topics for discussion by the teen leaders, and a lively debate or a confirmation of mutually shared experiences would follow. Occasionally, sensitive and provocative topics would surface, and everyone would leap in to contribute. During a break, for example, one of the young mothers told the group about a violent argument she had had with the baby's father during her pregnancy: "He would grab me by my hair. But no more! Now I'd say to him, 'I'll whup your butt.' " Another mother added, "My boyfriend sat on my stomach when I was pregnant." Clearly, these sessions provide a safe haven and an atmosphere that allowed for self-disclosure and openness among the participants.

Although the predominant goal of the group training sessions and follow-up support group gatherings was to empower the teen peer leaders to share their breastfeeding experiences with peers, the comments I heard revealed that these adolescent mothers were themselves in need of emotional support. In their daily lives, each struggled to cope with the baby's father, his extended family, and her own extended family. Every aspect of their lives involved multigenerational issues. One mother said, for example, "[My mother] said that I'm breastfeeding too long now…but [the baby] doesn't want to stop." During one session I attended, the young mothers debated this question at length: "How do you allow your baby to spend long periods of time with the father's family when the infant is exclusively breastfed?" Despite the daily dilemmas they faced, the teen mothers also talked extensively about their hopes and dreams for the future. They shared their plans for obtaining a GED or completing high school at an alternative school, going on for further schooling, or enrolling in college.

The challenges of adolescent parenting became apparent as a few of the teen moms disciplined their energetic toddlers roughly during a session. I found myself wondering what might have happened if the facilitator had used her talents for flexible adaptation to refocus the discussion to the discipline of young children from a developmental perspective. Spontaneously generated conversations pertinent to the parenting behaviors observed during training sessions might help teen mothers become conscious of their dual roles as peer leaders and nurturing parents. Then a secondary benefit of the program would be the individual growth of young mothers as responsible parents, gaining a

solid understanding of a baby's developmental needs.

Another illustration of the flexibility required to adapt the "topic of the day" to the needs of the teens occurred at one of the follow-up get-togethers. The focus of the session was on making and maintaining contact with clients. What emerged from the discussion was a thoughtful reflection on family values. One peer counselor talked about the teen she had just met and was trying to help. This young woman had been humiliated in front of her church congregation by her mother and grandmother, who voiced their anger and disapproval about the young woman's pregnancy. Although some of the teens found it hard to understand that families would actually find fault and openly blame the young woman for her predicament, others were quick to tell of their own struggles and conflicts within their families, especially with their own mothers.

In the Teen Peer Leader Program, young mothers begin to see their lives and actions as having real meaning and significance.

Accountability and Achievement

CHC program facilitators realize that creating and sustaining a comprehensive training and support program for teen advocates is not an easy task. It is difficult to establish realistic, measurable goals and outcomes for a program whose participants are in a major transition period in their lives. Pressures of school, work, and parenting, along with active participation in the program, all require the teen leaders to shift priorities constantly. A parenting teen may find that working through the developmental tasks of adolescence, such as emancipation from family and the establishment of career goals, can be daunting. Not all teens who agree to participate in the Teen Peer Leader Program stay with the program for long; others, however, value the connection and support the semi-monthly meetings provide. Program developers and facilitators who are working with teen mothers and their children face their own set of challenges: It is not easy to work with young women trying to find their place in a society that places little value on young women of color who have discontinued or interrupted their education in order to parent (Goldberger, 1996).

Given these pressures, the program works hard to find ways to support the teen advocates' networking endeavors so that their energy is focused appropriately on what they have set out to do — reach out to other teen mothers in the hopes of influencing their breastfeeding decisions. One follow-up session, for example, was devoted to brainstorming ideas on breastfeeding promotion activities. The teens offered many suggestions for appropriate places to connect with peers, such as their own high schools or parenting support groups. One teen leader suggested the Medicaid office, observing, "You know everybody there has children." Others suggested the mall, community health fairs, local clinics, and churches. "We should put out flyers!" one teen shouted. Another mother said, "My high school wants me to come back to talk to the girls about breastfeeding...The teacher said I could relate to the teen moms." The young women are encouraged to think of ways that they can fit the promotion of breastfeeding into their lives. Having and keeping a schedule, time management, and developing organizational skills and professional behaviors are important aspects of this process.

In the program, teen leaders begin to see their lives and actions as having real meaning and significance. "Can you imagine, being paid to do something you love?" one young mother asked, referring to the stipends leaders receive for making contacts and follow-up phone calls. "I just like talking to people," another teen peer leader stated simply.

Viewing Teens as Leaders

More than 30 years ago, Angela Davis (1971) identified those "loud black girls" — young women who have difficulty conforming to the standards set by a society that is insensitive or unwilling to understand their needs. More recently, Goldberger (1996) used "voice" as an organizing metaphor for women marginalized in society. The facilitators of the Teen Peer Leader Program worked constantly to engage and sustain the attention and active participation of the participants so that each could find her own voice and envision herself as empowering others by using their voices.

Regularly scheduled meetings could become quite boisterous as teen peer leaders established their own agenda and moved the topic under discussion in a different direction from the one the facilitators has planned. Flexible facilitators realized how important it was for these young women to tell the stories of family strife, financial issues, boyfriend blues, violence, and "gang-banging" in their communities.

Teens bring "here-and-now" issues to any group discussion (Rosenbaum, 1984). But for teens to benefit fully from the Teen Peer Leader Program, the program developers and facilitators needed to integrate leadership skills with personal development, social development, and emotional expression. How do we define and teach leadership skills to a diverse group of low-income teens who happen to be parenting? Leadership has to be taught within a developmental context. Team Peer Leader Program training sessions proceed from the premise that teen parents are individuals who are capable of growth and leadership development at a time when they are highly motivated and excited about their newfound opportunity to tell the world about breastfeeding.

For these young women, the act of breastfeeding becomes a powerful metaphor for success. These young

women were all influenced and encouraged by someone to breastfeed their babies. They found the experience empowering. They came to believe they could make a difference in the lives of other teen mothers. They are confident because of their success at breastfeeding; now they want to do more with their lives. When the teen peer leaders realize their voices are heard and respected in the safe, nonthreatening environment of program training and follow-up sessions, their self-confidence is evident. It is a genuine turning point.

Teen Peer Leader Program training includes the notion of personal accountability while embracing the concept of establishing supportive relationships among a network of peers. When channeled appropriately, this concept can be transformative for the teen peer leaders. For example, teen mothers participating in the program must come to see themselves in a relationship with their own children and their peers, and to see these relationships as bringing each other along, establishing mutual respect and support. The facilitators and the design of the training program help young mothers realize that as they become more self-reliant in their lives and independent in their thinking, they can use the concepts of self-reliance and independence in their relationships with their peers and their children. Facilitators expect that the teen leaders will then be able to see their own children as individuals capable of thinking independently and seeking self-reliance.

Through group discussions and peer leader activities, young women in CHC's Teen Peer Leader Program learn to value their personal experiences, insight, and intuition. When they begin to understand that they have the capacity — and the right — to have a say in the running of their own lives, they begin to behave like leaders, both individually and collectively. They realize that they can use their voices to help themselves and to help others.

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EXTENDED CARE

Family Child Care, Family Support, and Community Development in Low-Income Neighborhoods

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PHOTO: KENNETH LAYMAN

I would just say as far as family child care, the other important aspect is that sometimes a young person, maybe even a single parent, they might need that family atmosphere…'cause a lot of people adopt us, and they go to calling my mother "grandma" and calling me "auntie." So I think that family child care is good for providing a substitute family where someone may need [it].

It's almost like a family would help me and a friend. It's in-between…It was like she was my older sister.

Well, not only that she's the neighborhood watch. She just, I don't know, there's just something about this lady, she help everyone. It's not just the kids, but in the neighborhood too.

So she's into, you know, keeping the neighborhood safe. It's just not her day care that's on this block, she is concerned with the neighborhood.

These statements are from interviews with family child care providers and parents of children in their programs who participated in a qualitative study that explored the contributions of family child care providers to family and neighborhood support in a low-income, African American community. We learned that family child care providers might be in a unique position to provide support and help to parents and neighborhoods, especially those under economic and social stress. The home-based setting and informality of family child care encourage some providers, as an extension of their child care work, to develop personal relationships with families that build social networks and increase community cohesion in their neighborhoods. This article will highlight how findings from the study inform our understanding of the complex supportive and caring role that such home-based paraprofessionals play.

at a glance

- A study of African American family child care providers in low-income neighborhoods found that they offered unique supports to families (extended and flexible hours) and community (neighborhood watch).
- All of the providers described education as part of their formal programs.
- Providers often adjusted or waived costs for parents in need.
- Older providers often informally mentored or assisted parents, while younger providers gave friendship and emotional support.

Family Child Care in the US

Family child care is care provided to non-relative children by a caregiver in her own home. Family child care providers typically serve small, mixed-age groups of children. Of the estimated 60% of all children under age 6 who are in a regular non-parental child care arrangement, about 13% are cared for in family child care homes — close to 3 million children (Hofferth, Shauman, Henke, & West, 1998). This figure is probably lower than the actual number of children in family child care, because many family child care providers care for relatives' children in addition to non-relative children. Low-income families and families with infants and toddlers are more likely to rely on relative care and family child care arrangements than higher income families and families with older children (Hofferth et al., 1998; Smith, 2000). Most states require that family child care providers who care for more than 3 children become licensed. However, many family child care providers operate outside any regulatory system.

Family child care providers help families with more than the direct care and education of young children.

Family child care providers vary greatly in their level of professionalism and the quality of the care they offer. While some providers hold degrees in early childhood education and consider themselves teachers, most family child care providers rely on their personal experiences as mothers and view their work with children as an extension of this familial role. Similarly, some providers offer educational programs and convert their homes into mini-preschools, while others integrate their child care programs into family life and daily household routines.

Study design

I interviewed 7 African American licensed family child care providers from 2 neighboring Chicago communities, both considered to be high-risk neighborhoods with poverty rates above 25%. The providers cared for 4 to 12 children at a time, who ranged in age from 6 weeks to 12 years. All the providers in this study offered child care to children from birth to 3. Six of the providers had been in operation for over 5 years. Providers ranged in age from 35 to 66 years. Four of the providers were affiliated with a local Early Head Start program and received resources and training from this site.

To recruit providers, I presented the study at a training class for family child care providers at the Early Head Start site and attended several monthly support group meetings held in providers' homes. The providers who were not part of Early Head Start were referred to me by a leader of a local provider association. These providers were recruited by telephone and visits to their homes to explain the project.

Given the small proportion of home-based providers who are licensed nationwide, it seems likely that the providers in this study are not representative of the population of home-based caregivers. Moreover, I believe that the providers in this study had more support and training than many providers in similar communities as a result of their Early Head Start affiliations.

I also interviewed 14 African American parents (13 mothers and 1 father) whose children were placed in these 7 family child care homes. Providers selected parents for the study. The parents included clerical workers, nurses and home visitors, a cook at a church, a security guard, a construction worker, and a special education teacher. Six parents were married, 3 were divorced or separated, and 5 were single mothers. Most of the parents were in their 20s, although they ranged in age from 19 to 45.

In my hour-long interviews with providers, I used a semi-structured interview protocol to focus on 3 domains: 1) providers' motivations for doing child care work; 2) providers' relationships with parents; and 3) providers' involvement in their communities. I interviewed each parent for an average of 30 minutes, focusing on the different kinds of support parents receive from their child care providers.

Open-ended interviews allowed providers to talk in depth about their relationships with parents and communities and the ways they conceptualize their work. Most providers spoke openly about the informal aspects of their work and some of their more personal involvement with families and neighbors.

Through thematic analysis of the interview transcripts, I constructed a list of common themes around informal help-giving and parent–provider relationships. I then re-read each transcript, coding for these particular themes, and used a word processing program to compile segments of the text relating to each code.

Findings

"It's more than just babysitting" — Caring and educating

I began my interviews with providers by asking them to describe the services they offer families and the formal aspects of their child care programs, such as hours, fees, transportation, and planned activities for children. All of the providers offer extended care (10 hours or more a day); 1 offered overnight child care. Providers typically open their doors from 6 to 7 in the morning and close at 5 or 6 in the evening. Several providers offer transportation for children to and from preschool or elementary school.

All of the providers described education as part of their formal programs. This is in contrast to recent studies that find family child care providers are less likely than center-based providers to report school readiness and child development as program goals (Hofferth & Kisker, 1992). Some providers in the study had converted their basements into mini-preschools with activity centers; others have children's posters on the walls, shelves of toys and books, and daily

schedules listing activities such as music, dance, and art. As one provider explained, "We want [the children] to be advanced... so when they start kindergarten and get homework, they know what to do."

Providers' hopes that child care could have a lasting effect on children's lives are embedded in this educational orientation. Several providers talked about their desire to make an impact well beyond the early childhood years. When asked to describe her goals for children, one provider responded:

> *I want to be one of those stepping-stones where* [the children] *have someone to lean on or to be able to, you know, enhance their abilities to go through college. That's my goal, to see them developing the different ages in life and when they become an adult, you know, see them in a positive role. You know, doing the same thing I'm doing — helping others. And basically, that's what I want and if I can accomplish that, we'll have a lot of positive people in the community.*

Parents in the study also focused on these educational aspects of family child care: "He already has his colors, his numbers, his ABCs. He says his name, his first name, his last name. He'll have all that before he gets to preschool." One parent termed the provider's program "just like a regular school" and another parent commented, "It's more than just babysitting. She is a day care provider and she also educates them."

Going the "extra mile" — Informal family support

The educational activities and formal program characteristics described above are consistent with professional development goals and ideas about "best practice" in early childhood education. Yet all of the providers in the study also reported spending a great deal of time and energy helping families with more than the direct care and education of young children. Throughout the interviews, providers were asked to talk about the kinds of support and help they offer individual families outside of their regular child care programs. Providers reported offering parents advice on a range of child-related issues such as toilet training, weaning, nutrition, and discipline as well as dispensing advice regarding child health-related problems. While a few providers give written materials to parents, other providers offer advice on an individual basis. Some of this advice reflects providers' personal ideas about child rearing rather than any written or "official" information.

In addition to giving advice, providers reported offering flexible hours to parents based on individual family needs. This includes keeping a child for an extra hour while a mother works late, or keeping children over a weekend when a parent has to go out of town. Several of the providers also reported offering occasional evening care. One provider, who offers 24-hour care, mentioned that she modifies the hours of her program depending on the particular needs of parents. Providers talked about this flexibility as a way to help parents in need: "To help her, 'cause I know she need to work. She's a young mother and I know when you need to work. She needs to pay her bills, you know." Parents also talked about their child care providers' flexibility around scheduling and hours. Some parents suggested that a provider's flexibility around scheduling was provided especially for them: "She went the extra mile" or "I don't know if all the parents do [ask for extra child care hours], but you know, I'm real close to her and I would ask her that."

All of the providers in the study emphasized their flexibility with respect to financial arrangements with parents. None of the providers mentioned charging late pick-up fees, a routine practice at child care centers. One provider talked about keeping children for a few extra hours on a regular basis without charging extra so a parent could keep a second job. Another provider offered to keep children free of charge while parents were looking for a job. Still other providers talked about trying to accommodate the needs of parents if they saw the parents as worthy of such help:

> *With me I'm flexible, it depends on their income. We have a certain rate but I'm flexible whereas I can go lower. I wouldn't go higher, but I can go lower if the parents are working and trying to do something for themselves.*

In addition to giving advice about child rearing and help with child care hours and payments, some providers offer parents a personal relationship. While all the providers interviewed describe themselves as playing "second mother" or grandmother roles to children in their care, some also emphasize their familial and, at times, maternal role with parents, especially young parents. One provider said, "My parents are very important to me, just like their children, you know. And when you have them for 5 or 6 years, you know, that's a family, you're family, you know." Another provider explained how the family aspect of family child care lends itself to this kind of extended or "substitute" family for single parents in particular. Older providers tended to talk about playing a maternal role with younger parents, offering moral advice and maternal wisdom, while younger providers talked more about developing supportive friendships or mentor relationships with parents whose own mothers were not available for them (see Bromer, 2001 for a discussion of provider–parent discourses).

Providers who view their relationships with parents as close described giving personal and emotional support. As one provider put it, "If there is something that I can help them with in a positive way, I would like to be there to help them." Another provider talked about her reason for getting involved in the personal lives of the families:

> *You know what? I feel it is a part of the job. Because it's still relating to the family needs, OK? And that's the goal.*

It's extended from not just the parent and the child. It's extended to whoever is around that child and parent. Because in order for them to be positive role models, people around them got to be positive too.

While a few providers reported giving parents advice around marital issues, other providers limit their emotional support to areas of educational achievement, which they see as related to children's well-being and therefore more in their purview as child care providers. They reported that education — encouraging teen mothers to complete high school and go to college — is their most important goal for parents of children in their programs. As one provider put it:

I really think they need the education so they can do better with their kids. I got one that has a little baby and she got one that just graduated and she's going to college herself and I tell her, "You just can't stop at where you at because you won't make enough money"... I try to tell them they need education.

Parents also reported receiving emotional and personal help from providers. As one parent explained:

You know she just tell you never give up. Like when I first came to them, I had just become a single parent and so you know by her being there and just talking with me ... that helped me along to have somebody to talk to. To know that I'm not out here by myself. So she just keep me encouraged.

"Keeping watch" — Neighborhood and community support

I asked providers to describe their involvement and activities in their neighborhoods and communities, both in their roles as service providers and as neighborhood residents. All of the providers reported extending the boundaries of their care to neighbors of all ages and to the well-being of their neighborhoods. As home-based providers, they keep an eye out for deviant behavior such as loitering or drug-related activity. They informally monitor the activity of older children and teenagers on the block during the day. Providers emphasized that everyone on the block knows that they provide child care and keep watch over the neighborhood. As one provider explained:

I keep my window cracked and you could stand out there right now for 5 minutes and every time somebody walk past they gonna look up if they drivin' or look up at the window. 'Cause they know I'm watching out... [T]he community knows the home-based day care so they're not going to stand in front of my house and litter or play loud music during my time... We do have a lot of drug slinging right in this area but they won't come on this block. ... [L]ike I say, I don't have to sit out on my porch anymore, I can just look out the window.

Another provider who no longer had young children of her own helped to keep the block safe for neighborhood children coming home from school:

When we as neighbors look out and we know it's almost time for our children to come home from school, we begin to start calling each other and then from there we start — maybe we need the police to just ride through, we'll do that.

Parents confirmed the involvement of providers in neighborhood social organization. One parent talked about the presence of 2 child care providers on the block as a deterrent to deviant behavior:

The bad teenagers know not to stand in front of this house. Not to stand near the house, you know. When, you know, these people around here know that this is a day care and also Mrs. Evans across the street, they know that if they want to stay out in front of the house and talk, she's going to call the police. And you won't be out there for long. She's not going to say nothing to you but before you know it, the police will come around and dismiss you, the disorderly standing around in front of the house, whatever. She helps with the Block Club, she's in charge of all that. So she's into, you know, keeping the neighborhood safe. It's just not her day care that's on this block, she is concerned with the neighborhood.

Another parent described how the provider's role in the neighborhood made him comfortable bringing his children to her home:

Well, not only that she's the neighborhood watch. She just, I don't know, there's just something about this lady, she help everyone. It's not just the kids, but in the neighborhood too. She started the neighborhood watch thing. Because if kids coming with their parents you want it to be nice. You don't want nobody to come up and kids out there selling drugs — that was never the case.

Some providers work with their neighbors to improve their neighborhoods for all residents. One provider helps to make sure that drug dealers do not take over a recently vacated house on the block. Another provider worked with city officials to get her street made a one-way street — safer for children and other residents.

In addition to community organizing, providers also reported helping individual neighbors with emotional and personal guidance, food, and occasional employment. One provider told me that she knows a lot of people in her neighborhood because she has lived there for many years. She talked about giving personal counseling and encouragement to people in trouble, referring to several young men and women on her block who had "hit hard times" or had drug problems:

There's a young mother that lives on this block and she got strung out on drugs and she got 5 babies. And I have talked to her for years. I have offered all kind of help. I have even went as far as giving money. Because I saw potential in her. I see so much, so many things in her. And I kept telling her, "You don't see it because you allowing the drugs to just take over your life but I see it." Don't you know about 3 months ago, she came and told me, "Mrs. Lewis, I enrolled in South Side Skill Center." I don't see her every day, but when she do see me she holler across the street, "I still hanging in, Mrs. Lewis." And she said, "I had to just come and tell you that because all these years you had just been talking to me and you encouraged me so much."

Other ways in which providers help their neighbors include employing them to do painting, plumbing, or trash removal; giving food and other material necessities to neighbors in times of need; or providing temporary housing to people who are homeless.

Conclusions and Policy Implications

Family child care providers serve children, families, and their communities as formal service providers and as informal sources of social support. Especially in times of stress, providers may serve as surrogates for family and friends who are not available to parents and neighbors. When providers offer these resources, they provide an additional layer of social support to parents and neighborhoods beyond the daily provision of child care. However, these informal helping activities and personal relationships may challenge efforts to professionalize family child care providers. The practices of offering advice regarding personal matters, providing after-hours care, and watching out for neighborhood children blur the boundaries between the personal and the professional — an important distinction often emphasized in training. Such personal involvement may interfere with monetary transactions or adequate supervision of children in care and may also lead to provider burnout. While flexible payments may be a way in which providers help low-income parents, such a policy could threaten the viability of the child care operation itself. Clearly the balance between professional business practices and empathy is a precarious one in family child care. The roles of mother, community organizer, and early childhood practitioner may potentially conflict.

In Conclusion

Findings from this interview study suggest that some family child care providers offer families and neighborhoods a range of informal social supports beyond the direct care of children. The flexible and intimate nature of home-based care may shape the kinds of personal involvements providers develop with families. Especially in times of family stress, providers have the potential to offer parents support and even lay counseling as well as friendship. Moreover, providers are visible to their neighbors as hard-working residents — they are home during the day and work long hours. In this capacity, some providers are involved in collective supervision and monitoring of children and neighborhood social network development. They may also serve as role models in communities for both adults and children. In addition to the formal services they offer young children, these more informal contributions may improve the lives of families and children.

The findings from this study have implications for both policy and program planning. There is an increasing trend in the family support movement towards enlisting informal sources of support in local communities in the development of more formal family support programs (Kagan & Weissbourd, 1994). Family child care providers may offer a unique combination of both formal and informal support to families, as shown in this study. Many policy makers believe that convenient, affordable, and high-quality child care will be necessary to make welfare reform work for single parents. Much of this demand is being filled by family child care providers, who are increasingly seen as a potential source of flexible care and family support. Indeed, as more parents turn to child care as a support system, providers may be expected and called upon to offer more than just child care to the families they serve. Yet these demands pose new challenges and questions for training and professional development efforts. While training should help providers become more professional in their work, it should also recognize the unique potential of family child care and support providers in their informal helping roles. Encouraging providers to share their experiences with each other in support groups may be one way to support providers. Such sharing may also lead to further collaboration and community strength.

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MOTHER, FRIEND, AND TEACHER: PERSONAL AND PROFESSIONAL HISTORIES INTERTWINE IN THE THERAPEUTIC FAMILY CHILD CARE PROJECT

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Suzi has been a nurse's aide for 14 years in a nursing home in Orange, the county seat of a rural county in Southern Illinois. Her daughter, Nancy, is expecting her first baby; she plans to return to college after the birth. Jean also lives in Orange, where she is an administrator at a college that is 2 blocks from her home and the bank where her husband, Tom, is an officer. Jean and Tom's son Ricky is a sophomore in college; his 3 brothers are in junior and senior high school.

Jean and Suzi both come from large families. Jean is the 11th of 13 children; all but one still live close to her. Jean considers her mother and her siblings her best friends. Suzi is the 10th of 11 children. Her mother died when Suzi was 10 years old. Suzi has been hospitalized repeatedly for psychotic depression.

I first met Suzi, Nancy, Jean, Tom, and Ricky in 1984, when I was establishing the new Therapeutic Family Child Care Project, sponsored by the Illinois Department of Children and Family Services (DCFS) (see sidebar, p. 40), that I designed and went on to direct. At the time, Jean was a full-time homemaker caring for Ricky, her first child, then 10 months old. She began caring for Nancy, Suzi's 2-year-old, and continued caring for her until Nancy entered kindergarten at 5 and a half. During those 4 years, Jean sometimes cared for other children in the community who were enrolled in the Therapeutic Family Child Care Project, but never for more than a total of 4.

Action research was integrated into all aspects of the project. Every week, providers completed an observation form for each project child. We then wrote comments on these observations and mailed photocopies to the providers. Every 6 weeks, project staff visited each provider's home and wrote verbatim notes of providers' and children's interactions. We mailed the notes to the provider, who added additional comments. Interviews of both project mothers and providers focused on their understanding of the meaning and purpose of the project and the quality of support they were receiving. In my fourth and final year as director of the project, I conducted life history interviews with the 12 providers I thought were most talented. Jean was one of our most gifted caregivers.

Promoting Development in Each Moment of Care

Development and education are embedded in each moment of care. Thus routine aspects of caregiving such as toileting, diapering, meals and snacks, and appropriate indoor and outdoor activities promote young children's development. Jean's mealtimes were full of spontaneous conversation — conversation that promoted the children's language development.

> Seated at the kitchen table are Jean, her son Ricky (21 months), project child Nancy (23 months), and project child Jason (25 months). The children are eating cereal and milk. Ricky sits in his high chair next to his mother. Ricky leans against Jean's arm, and she asks, "What is the matter, Ricky?" Ricky looks under the table. His mother asks, "What is down there?" Ricky says, "Cheerio." Jean says, "You found a Cheerio on the floor."
>
> Jason then looks at Jean and asks, "What's that?" Jean replies, "Ricky is looking at the cereal on the floor. Did you spill any?" Jason replies, "Yep." Jean says, "Another mess." Ricky repeats, "Another mess." Jean says, "Who will clean it up?" Ricky says, "How about me?" Jean says, "How about you? Okay, but let's finish your cereal first." Ricky repeats, "Finish my cereal."

Given the extensive conversations of Jean and the toddlers, eating often took 30 to 45 minutes. Jean repeatedly elaborated on what each child said, and sometimes asked them simple questions.

A distinctive feature of this project was the involvement of husbands. At rural sites, most husbands ate noonday dinners with their

wives and young children. Jean described Tom's daily dinner with her and the children:

> *Each day Tom eats dinner with us. While I do the dishes, Tom reads stories to the children. As the morning progresses, often the children will ask, "When is Tom coming home?" They love cuddling on his lap or at his side as he reads.*

Family child care providers have unlimited opportunities to engage in spontaneous conversations with the children, both when the children are playing and when they are engaged in routine tasks. With babies, providers talk about what they and the babies are doing in order to help the babies feel connected and stimulate the babies' babbling:

> Jean sits on her living room couch as her son Ricky (20 months) and project child Nancy (22 months) play on the rug. Both toddlers have their shoes off. Ricky says to Jean, "Wear Nancy's shoes?" Jean replies, "Do you want to wear Nancy's shoes? Ask Nancy if that is okay." Ricky says to Nancy, "Okay, Nancy?" Nancy replies, "Okay." Ricky then goes to the table and gets Nancy's shoes as he says, "Here them." Jean says, "Here they are. Have a seat and I'll help you." Ricky says, "Have a seat." Nancy then wants to put on Ricky's shoes, and Jean helps her do so as they talk about the process.

Nancy had entered the project 6 months before the above instance with no language, and was slow to interact with adults and children. After 6 months, she talked frequently in 2-word sentences and loved to play with Ricky and the other children.

In activities such as simple story dramatization and cooking, adults

PHOTO: JANET BROWN MCCRACKEN

can structure turn-taking so that each individual's participation adds to the group process. Even young toddlers can enter into turn-taking when it is clearly structured by an adult, as illustrated in the following vignette:

> Ricky (18 months), Nancy (20 months), and Mary (3 years) are seated at the kitchen table, along with ingredients and tools for making biscuits. As Jean pours flour into the mixing bowl, she says, "Okay, it's Nancy's turn to put some flour into the bowl." Nancy pours the flour into the bowl; the other 2 children have their chance to pour other ingredients into the bowl. As the children wait for their turns, they make circular motions with the flour on the table. When Jean gets the milk for the biscuits, she gives each child a small cup of juice. The children then take turns mixing the batter. Jean gives each child a cookie-cutter and helps each child cut out the biscuits and put them on the cookie sheet.

Jean and the children cook several times each week. With experience, the children have learned that they always will have a turn. They have also have begun learning about social responsibility — they can each participate in the making of dinner or a snack.

Conflict as a Context for Learning

Rules are the *sine qua non* of young children's successful group experiences. Understanding and following rules are essential for young children to learn how to self-regulate — that is, to learn how to make adaptations to adjust to either environmental demands or their own goals. When caregivers consistently observe the children playing, they often anticipate potential conflicts or safety hazards and redirect the children's actions before a problem arises.

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Ricky (18 months) rides a wooden horse around the living room. He then stops and stands on the horse. Jean says to him, "Ricky, I don't think that is safe. You ought to get down. Otherwise the horsy might fall and you would bump your head on that chair." Ricky gets off the horse and knocks it over. Jean asks, "Is the horsy okay? Did he get hurt?" Ricky says, "Check and see. Oh, horse ouch-y." Jean says, "The horse has an ouch-y. Let's get a Band-Aid."

Toddlers like Ricky constantly explore and experiment but have little capacity to judge potentially dangerous situations. When Ricky stood on his horse, Jean could redirect his potentially dangerous action with a positive explanation that he could understand, then engage in dramatic play with him.

Jean is always with the children as they play in the living room or small playroom off the kitchen. When caregivers like Jean are observing young children and the children enter into a conflict, the caregiver can use this conflict to promote the children's understanding of feelings, intentions, and the need for turn-taking. In other words, conflicts can become contexts for substantive learning:

> Ricky (22 months) and Nancy (24 months) play on the living room rug as Jean sorts laundry. Nancy gets on the school bus and begins to ride around the living room. Ricky tries to push Nancy off the bus. Jean tells him, "Ricky, Nancy is taking her people for a ride. I know you want to take a ride also. Let's wait until her people come home. Then you can give your people a ride." Ricky goes to the toy box, gets out a car, lies on his stomach, and moves the car back and forth.

Because Jean was observing the children, she understood the children's experience and could redirect Ricky's action within the context of his play. She could verbalize Ricky's intention; since he understood turn-taking, he could be satisfied with another form of play while he waited for his turn with the bus.

Benefits for Child and Parent

Before she was enrolled in the project, Nancy spent her days either in a crib or a playpen. She came to Jean with significant developmental delays. After 6 months in the program, Nancy's actions were age-appropriate; in fact, she was one of the quickest children.

Suzi grew in her role as a mother. Part of Jean's job as a family child care provider was driving Suzi home on the days she visited Jean. When Jean took Suzi home, she often helped Suzi with parenting and homemaking skills. For example, she taught Suzi how to bathe Nancy, and together, Jean and Suzi often made brownies, soup, or spaghetti. Jean described her relationship to Suzi with the following:

> *Sometimes I'm a mother to Suzi, and sometimes I think I'm a friend, and sometimes a teacher. You know she had no mother after she was 10. Sometimes she'll call me on the phone and ask me to come help her. Like last week she asked me to help her make an apple pie, just things she doesn't know how to do. But there are some things she does real well, like doing her laundry or cleaning her house. At my home, right after dinner, she always gets the broom and sweeps the floor. I've never asked her to do that; she just knows she's comfortable helping me with housework.*

Once enrolled in the project, Suzi ceased being hospitalized for psychiatric care. With the help of Jean and her psychiatrist, Suzi became strong enough to begin working as a nurse's aide at a local nursing home. In an interview with the director of the Therapeutic Family Child Care Project, Suzi described how she had changed since she entered the project:

> *I am calmer now and more patient and enjoy doing things with Nancy. I used to want her to leave me alone*

The Therapeutic Family Child Care Project

In 1984, the National Center for Child Abuse and Neglect funded the Illinois Department of Children and Family Services (DCFS) to implement the Therapeutic Family Child Care Project in 3 rural counties in Southern Illinois. A year later, DCFS took over the project and expanded it to 3 metropolitan areas in the same part of the state. Women who had been homemakers and white-collar workers were hired as family child care providers. They cared for young children in their homes 35 hours a week, also providing transportation. Weekly, mothers enrolled in the project assisted caregivers for half a day and attended a parent meeting. These activities were designed to improve their caregiving skills and increase their understanding of their young children.

Project staff used several strategies to enhance family child care providers' understanding of young children and caregiving. After an initial 2-day training session, the project director offered semi-monthly training sessions for all providers. After 4 years, the project tripled in size and management was transferred to a local social service agency. Currently, the project serves over 100 children in 3 rural counties and 3 metropolitan areas.

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PHOTO: MARILYN NOLT

because I didn't know what activities to do with her. Now I enjoy being with her. I like to give her a bath best of all. At first I couldn't figure it all out, but Jean always gives me ideas that really help. I also have learned that if I say "No" and am consistent, things work better. I used to give in because I thought it was easier. I also let Nancy extend herself more before I say "No." I have broader limits than before.

Nancy and I play Ring Around the Rosey and we roll about the bed together. We also watch Sesame Street *and* Mr. Rogers *together. Jean has loaned me some children's books and Nancy loves me to read to her. We read together for about 45 minutes each day. I just couldn't believe that Nancy was so interested in books! Jean always reads to the children and I try to do some things like she does. I used to think,* ["Do I have to go over there for the required weekly half-day visit with Jean?"] *Now I wish every day was Thursday. And I get to help sometimes. We always try new recipes and Jean gives me them to try at home. I have learned a lot about nutrition and I like the way Jean gets Nancy to try new things. From Jean I learn ideas for play, how to be willing to try new things, and to play with Nancy, not just have her play by herself. I have told some things to Jean that I have never told any one else. It makes me feel that I am not alone — to have a friend like Jean.*

Jean's patterns of child rearing offered Suzi an alternative model of mothering. Through her relationship with Jean, Suzi learned new skills in mothering, homemaking, and self-conception.

Conclusion

As I worked with the project's family child care providers, I was often astonished at the talent of these women and the substantive development of the children under their care. In an effort to learn the underlying dynamics of the project, I chose to conduct life-history interviews with 12 of the most talented providers. Through this process I learned how these women's personal and professional histories were intertwined.

Like Jean, the talented family child care providers I interviewed spoke of their work with young children as pivotal to how they understand themselves and their place in the world. They did not think that what they did was just a "job." They often contrasted their work as caregivers to prior work in offices, banks, restaurants, nursing homes, and stores. They said that they brought their "whole selves" to work in child care.

Each of these women described how work with very young children and their parents was central to her identity. When I asked what about the care of children that was so important to them, the answer, consistently, was relationships — relationships with children, parents, and other project staff members. I remembered the stories they had told me about being close with friends and families as children and as adults, and this answer made sense to me. Family child care providers in the Therapeutic Family Child Care Project felt most like themselves in intimate interaction with people with whom they were close.

LIFE-SAVING PEOPLE

To the Editor:

Thank you so much for your June/July issue, with its exploration of how various centers support parents during the crucial months before and after their infant's birth. The quotations from parents in Duluth testify to how successful these interventions are.

I remember many years ago hearing the psychoanalyst Eleanor Galenson describe the program of early intervention in the Therapeutic Nursery in the Department of Psychiatry of the Albert Einstein College of Medicine. Many mothers seeking help for their babies had problems so severe that concrete suggestions and support were useless; mothers could not take part in the bonding an infant needs in the early days, weeks, and months of life.

The same therapist was assigned to both mother and infant. Therapy with the mother was, of necessity, long-term, focused on improving her mental health and her capacity to bond with her next infant. The therapist formed a bond with the infant to supplement what the parents could not give, and helped the family find substitute mothers for the child.

As a psychoanalyst treating adults, I have often wondered how some of my patients turned out so well, considering how unavailable their mothers were because of depression or severe narcissism. Where did they get the "maternal preoccupation" that enabled them to become strong individuals? In time, a loving father, an older sibling who cared for the child, a housekeeper, an aunt who visited once a week, or a close neighbor always emerged from memory, soon joined by friends and special teachers as the child grew. Gifted children dealt with deprivation and hardship by turning to nature, as young Virginia Woolf bonded with plants, the sea, and light, or Beethoven, from his attic, stared out across the Rhine to the Seven Mountains.

One of our jobs as analysts is to call up the memories these life-saving people — pieces of the patchwork mother who has served so admirably. Once remembered, this "mother" is available inside the self to bolster patients' strength to face and understand the pain that has restricted their lives.

In addition, as a neighbor and "Aunt Bobbie," I am happy to have added a piece to the maternal quilts of 3 of the babies who appear with their mothers in this fine issue.

Barbara Young, MD
Baltimore, Maryland

Barbara Young's photographs appear regularly in the Zero to Three *Journal and other ZERO TO THREE publications. She has also written for the* Zero to Three *Journal. Dr. Young's essays on Virginia Woolf are available on-line in the* Yale Journal for Humanities in Medicine *at http://info.med.yale.edu/intmed/hummed/yjhm/regular/byoung1.htm.*

MUSIC IS MAGICAL

To the Editor:

The issue of *Zero to Three* Journal on the musical lives of infants and toddlers was so exciting that I scarcely know where to begin. I always knew my mother was an early childhood genius. At age 39, pregnant with her first baby, she used her 20 years of experience teaching in a one-room school to influence me, her unborn daughter. Day after day, she sang songs to me in her womb in the hopes that she would produce a musical child. After my birth, daily renditions of "Bye-o Baby" sung to *Red River Valley* were used to quiet me. Before I was 3, a Hollywood casting studio recorded my nursery songs and offered me a substantial part in a movie. But Kansas called, so I experienced a life filled with music lessons of my choice, then partnership with my mother in her large day care center. As an adult, I agonized between the choices of working with children or being a professional harpist, but finally decided that children would take priority.

In the mid-1960s, looking for a way to combine my 2 passions, I became fascinated that so little had been written about children's music development. I embarked on a research project at Tufts University for my thesis that focused on 4-year-olds' spontaneous singing. I transcribed and analyzed 160 songs collected from 32 children (16 boys and 16 girls) at Eliot-Pearson Children's School as they went about their activities during a typical preschool day. What I learned was so interesting that I thought about making a career of studying the development of music from birth, across cultures, longitudinally, with large numbers of children at various ages.

Instead, I pursued another passion — working with the mental health issues of young children and their families. Nevertheless, as I worked, songs popped into my head — therapeutically themed songs with simple melodies. Using my framework, young children and their families began to add their own verses to common questions such as, "Sometimes I feel very mad. What should I do about that?" Teachers, parents, and children looked at scenarios, solutions, and consequences in the course of developing songs. I was convinced that this new gift sprang from my year of listening to and collecting 4-year-olds' uninhibited, creative outpourings. The songs came so fast and furious that I gathered them in a book: *Swinging on a Tune: Songs for the Very Small and Very Tall* (Emporia State Press, Emporia, KS). The title grew out of a phrase from 4-

year-old Melanie's song: "You can be happy, swinging and singing. You can be happy, swinging on a tune."

Since then, music has accompanied me on all of life's journeys. I am delighted that so many researchers are now studying the importance of music and its use for strengthening relationships and serving as a source "of inspiration and emotional fulfillment" (Trevarthen & Malloch). In the past several years I have worked with a Parent–Infant group sponsored by a Topeka, Kansas hospital that is open to all families with infants and toddlers. The most beautiful moments in these groups came about when we ended each session with Mister Rogers' "Tree Tree Tree," changing "Tree" to the name of each child. "Evan, Evan. Evan, Evan. Evan, Evan. Evan, Evan. We love you. Yes we do. Yes we do. We love you." At the close, every baby in the group would quiet, and love would fill the room. Everyone now had a simple but magical song that worked wonders when babies were fussy and parents exhausted.

So, where should we go with all this? We must see that music development gets into our child development textbooks. We must help all grownups conquer their inhibitions about singing. We should know how to use music therapeutically with special groups (depressed mothers, NICU babies, etc.) and encourage the use of culturally familiar songs for everyone that comes through our doors. Music and movement can bring joy to socializations in Early Head Start and help fathers feel more comfortable with singing or instruments. Finally, we must continue this research. How, for example, does the often loud, continuous rock music played by adolescents affect their babies? And how are all of us affected cognitively and emotionally by the music that surrounds us at different stages of our lives?

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In Tune With Trevarthen

To the Editor:

"Early musicality has a powerful role in building memories. It marks with emotional signatures the identity of persons and ritual events. After very few months an infant can 'make music,' and seems to have found a proud performer's personality."

—Colwyn Trevarthen and Stephen Malloch, *Zero to Three*, September 2002

Prior to becoming a father, as an infant psychiatrist I observed and wrote about the following phenomenon: In intergenerational transmission of violent trauma in families, a traumatized parent draws his infant's attention to the parent's trauma-related cues like one playing charades (Schechter, in press). The parent's sudden gestures — a compulsive, non-verbal communication of his experience to his child — have the rhythm, intensity, and unpredictability of violence, and only he knows their meaning. Clues pile upon clues until the child gains some implicit understanding of the parent's negative experience, then responds to the parent's cues in such a way as to co-construct a new experience for the dyad — albeit a parent-driven one. The scene repeats with near-endless variations in multiple contexts, apparent only to us, clinical observers, as a traumatic reenactment that leads to affective dysregulation.

After becoming a father, I realized the "transmissions" I had studied in intergenerational trauma occurred all the time in everyday interactions between parents and their young children, albeit in less extreme, more mutual ways — ways that can be regulating or dysregulating. We as parents desperately want our children to know our experience, good and bad. In action and in language, we want to give them not just our genetic material, but the essence of our psychological and spiritual being. With my son Jan, that has meant drawing his attention to music and everything that music means to me. It's hard to do otherwise — even tapping my fingers to a persuasive rhythm gets him imitating. He wants to experience what I experience and hates being left out.

While most kids between 11 and 12 months of age would have reached the milestone of blowing or trying to blow a bubble, Jan, ecstatic, "plays" my recorder and actually gets a tone out of it. He shows special pleasure when I take out my cello, smiling broadly, dancing up and down excitedly, then settling back to suck his thumb comfortably and observe me with very wide eyes.

Before becoming a child psychiatrist (or a father), I attended a conservatory of music as a cellist and composer, then received a masters in and taught music at Columbia. Only when music had to pay the rent did it cease to be "fun." By that time, I had become excited about my work with infants and families as a volunteer at a clinic in a New York hospital. I went to medical school, where, during my residency, I met my wife, who worked in the university cultural center where I rehearsed weekly in a string quartet. She is an amateur oboist.

Jan's musical immersion occurred literally at birth. When my wife went into labor, I grabbed my one and only Music Minus One (MMO) CD, a recording of a C. P. E. Bach (J. S. Bach's son) cello concerto. (Already, I held a father–son ideal in hand and mind.) The OB staff and I were humming that MMO music as Jan was born that evening — my wife listening but otherwise engaged. It so happened that he was born during the Allegro Vivace, when both the cello and oboe are prominent in the orchestration.

Since Jan's birth, every morning we have engaged in what he now calls, in his toddler lingo, "Da-doo da[nce]." It's a special activity for the

2 of us (it's not something he does with mom, at least not in the same way). We dance to Lecuona Boys *Conga Train*, hip-hop, and Brahms string quintets. Occasionally, Jan will shake a maraca or a bell. He likes to play as we go, sometimes inviting his stuffed lion to join us, at other times, an alarm clock.

On a recent trip to a ZERO TO THREE Fellows' meeting, I called home. My wife put me on the speakerphone for Jan to hear. When Jan heard my voice, he shouted gleefully, "Da-doo da[nce]," and reportedly started to stamp his feet in a make-believe Lecuona Boys *Conga Train* move. I sang a few bars. He sang back. We were as cheek to cheek — holding each other in our minds across 500 miles, just as close as we had been on any given morning for the past 15 months.

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Capturing Young Children's Musical Imagination

To the Editor:

I agree with a number of the contributors to the *Zero to Three* Journal that parents and caregivers' intuition leads them to musical communication with babies, but common notions about music learning do not lead them to meet children's musical needs. Babies and toddlers are wired for more sophisticated musical interaction than has traditionally been thought or practiced.

The field of music education has done extensive research in the past 30 years to uncover the developmental process of music-learning in the very young child. Birth to 3 years is the window of opportunity for music development, just as it is for language. Music-learning parallels language-learning in many respects. Both require extensive exposure, interactive models, and the opportunity to babble. Both demonstrate that the richer the environment, the richer the babble, and the greater the development. Both are sparked by the intuitive interaction between mother and child, and both have to be nurtured throughout early childhood.

Language has the advantage of skilled models and common usage in daily activity and play. Music development needs the same. Musical play in rhythm, melody, and movement activates the child's musical mind and stimulates self-initiating musical behavior. For example, if a toddler with a classic toy hammer interacts with a musical model that is chanting and pounding a toy hammer rhythmically, the child will not only imitate the model, but also initiate rhythm babble in the same meter when playing by himself with the hammer.

Traditional songs and rhymes that delight children and caregivers have enriched the lives of generations. They do wonders to stimulate interaction, expression, and language skills, but they are not the most beneficial songs for music development. Music education research has identified more "nutritious" musical content for music-learning in the very young child. Babies and toddlers are spellbound by songs and chants *without words* in various tonalities and meters. These capture children's "musical imagination" more powerfully than the songs we assume to be essential to childhood. Further, they stimulate more sophisticated musical response than do favored songs.

Language offers lovely stories, like those of Margaret Wise Brown, to complement the rich folk tales and nursery rhymes of childhood. Music has traditionally provided only folk songs. Art songs for little children are now emerging in the field of music education. (www.comechildrensing.com). These songs are an outgrowth of research identifying children's developmental musical needs and children's soaring musicianship resulting from that research. Art songs and play songs in various tonalities and meters allow children of tender ages to engage in the essence of the musical art.

We have only begun to tap the artistry of very young children. Little children need a musical environment with appropriate musical models, ample opportunity for movement and musical play, and rich musical content that captures and develops the "musical imagination." With such musical substance in the lives of young children, the researchers presented in your recent issue will find surprising musicality to report as children and parents grow together beyond the innate musical communication cited.

Mary Ellen Pinzino, Director
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From a Songwriter Dad

To the Editor:

Music — talk about an international, cross-cultural, and cross-generational means of expression! But bring up music for children and watch the opinions fly! My Bach is better than your Barney. My Pooh Bear can beat up your Itsy-Bitsy Spider. Mozart will make you smarter;

Elmo will fry your brain.

I've been a songwriter–producer for 10 years. For 5 of those years I've been a songwriter–producer Dad, and I've learned 2 things. One, Sly and the Family Stone had it right: "Diff'rent strokes for diff'rent folks." Why intellectualize it? Call it genetic, environmental, media-induced … different kids like different music. Wait 5 or 10 years, and they'll like something else.

Sorely lacking for today's family is music that parents *and* children can love and share. When our lullaby CD, *Dream With Me Tonight*, was released in 2002, parents nationwide responded with one voice: Thank you for giving us real songs that our children love that don't drive us crazy! That confirmed my own beliefs when writing the CD, which won 4 children's music awards: Too many of today's children's songs are either written down to kids to the point of being mindless ditties, or else they are wrapped in the promise of producing smarter babies. Jeez — do we really need smarter babies? In fact, some of the smarter kids I've seen could use a little chilling out.

And yet music plays an undeniable role in all our lives, starting even in the womb. According to Giselle Whitwell, a practicing prenatal music therapist, in her article, "The Importance of Prenatal Sound and Music": "The elements of music, namely tonal pitch, timbre, intensity and rhythm, are also elements used in speaking a language. For this reason, music prepares the ear, body and brain to listen to, integrate and produce language sounds. Music can thus be considered a pre-linguistic language which is nourishing and stimulating to the whole human being, affecting body, emotions, intellect, and developing an internal sense of beauty, sustaining and awakening the qualities in us that are wordless and otherwise inexpressible.

"The famous British violinist Yehudi Menuhin believe[d] that his own musical talent was partly due to the fact that his parents were always singing and playing music before he was born." (http://www.birthpsychology.com/lifebefore/sound1.html)

I think one reason why songs like "Itsy-Bitsy Spider" and "Rock-a-Bye, Baby" are handed down through the generations is that — like Christmas carols — there aren't that many good ones being written these days. Let's face it, "When the bough breaks, the cradle will fall…" is nobody's idea of a comforting, relaxing image for an infant at bedtime. And Mozart, Brahms' "Lullaby," or Pachelbel's Canon are great the first 20 times or so, but a parent can only take so much!

So, when all the research is done and the numbers are crunched, Moms and Dads still need to get their precious little snookums to bed in one piece. And we parents still need to share hour after hour of rocking in the nursery or dancing in the den with our kids. The songwriters and record labels need to create better material for us to choose from. And parents need to search a little harder for the appropriate soundtrack to their family's lives.

Wouldn't it be nice if there were more songs out there that we as families could love together?

Like Mozart.

No – Mickey!

No – The Beatles!

No – the Itsy-Bitsy Purple Dinosaur!

Lanny Sherwin
President, Sandman Records
www.DreamWithMeTonight.com

Lanny Sherwin is the father of Alec, 5, whose favorite song is "Splish Splash."

PUBLICATIONS

Across the Street From Adolf Hitler

(2001) Anneliese Korner-Kalman (Xlibris: www.xlibris.com/bookstore, 888-795-4274 x276) $28.97 hardcover, $18.69 paperback, plus $4.48 shipping and handling.

Anneliese Korner-Kalman, a ZERO TO THREE Board member for over a decade, was born in Munich and during her childhood lived across the street from the apartment house where Hitler lived — first in secret and then as Fuhrer, surrounded by SS guards. In this memoir, Korner-Kalman reflects on her upbringing as the youngest of 3 children and the only daughter ("Mine was a difficult birth, a fact my mother rarely let me forget"); her serendipitous meeting and life-altering apprenticeship with Jean Piaget, which began when she was sent to Switzerland after an interrogation by the Gestapo; her emigration to the United States in 1938; and her career as clinical psychologist and research scientist.

During 20 years as a clinician, Korner-Kalman constantly wondered why some individuals who had undergone traumatic childhoods thrived, while others with relatively benign family histories suffered significant mental illness. She became a researcher in the 1960s, investigating, among other questions, behavioral differences among newborns, the increases in active visual scanning produced by holding babies to the shoulder, and the effects of waterbeds on the neurobehavioral development of preterm infants. Korner-Kalman's Neurobehavioral Assessment of the Preterm Infant

(NAPI) is now used in countries all over the world.

The First Years: A Parent & Caregiver's Guide to Helping Children Learn

(2001) Janet Pozmantier, MS, LPC, LMFT, RPT, Joanne Go, MS, EIS, BAT, and Laurie Segal Robinson, MA, LPC, LMFT (DK Publishing, 95 Madison Avenue, New York, NY 10016) Hardcover. $14.95.

With a foreword by Rob Reiner, founder of the I AM YOUR CHILD Foundation, which promotes greater investment in and public awareness of early childhood development, *The First Years* details the milestones at each stage of a child's growth from birth to 3, including language acquisition, play styles, and emotional and physical needs. The book divides a child's developmental periods into 3 major sections: "Getting to Know Me," from birth to 9 months; "I Can Do It Myself," from 9 to 18 months; and "On My Way," from 18 to 36 months. Each section explores issues such as feeding, touch, play, and sleep, with special attention to the questions, problems, and opportunities that arrive at each stage of development. Sidebars offer tips to parents and caregivers. For example, sidebars in the toilet-learning section list ways to make toilet-learning "fun" and cite mistakes to avoid while teaching children to use the toilet. Illustrated with more than 75 color photographs of adult–child interactions, *The First Years* is written in layman's terms.

The Doula Book: How a Trained Labor Companion Can Help You Have a Shorter, Easier, and Healthier Birth

(2002) Marshall H. Klaus, MD, Phyllis H. Klaus, CSW, MFCC, & John H. Kennell, MD (Perseus Publishing, www.perseusbooks.com) Paperback. $19.

A doula — the Greek term chosen by the authors literally means "woman caregiver," and encompasses the wide range of baby helpers — is a knowledgeable, experienced birthing guide who works before the birth, during labor, and in the perinatal period to calm, educate, and support the mother and father. In *The Doula Book*, Marshall and Phyllis Klaus and John Kennell suggest that during a typical pregnancy and childbirth, a doula may explain medical interventions; supplement the nurse or midwife; serve as an experienced party alongside a supportive husband; serve as the woman's advocate with family and medical staff; help the mother control her pain through relaxation and breathing techniques; explain each stage of labor to the mother and father; and serve as the liaison between the family and hospital staff. The obstetric benefits of doula-assisted births include: reduced rates of cesarean deliveries, epidurals, and episiotomies; shorter labor; fewer maternal fevers; and healthier babies. Use of doulas may also increase success at breastfeeding, and lessen the incidence of postpartum depression. Additional chapters describe one woman's doula-assisted birth, discuss fathers' roles during labor, and analyze the success of the doula program at the National Maternity Hospital in Dublin, Ireland.

Enhancing Early Emotional Development: Guiding Parents of Young Children

(2002) Jean Wixson Gowen, PhD, and Judith Brennan Nebrig, LCSW (Paul H. Brookes Publishing Co., Post Office Box 10624, Baltimore, MD 21285, www.brookespublishing.com) Paperback. $29.95.

Gowen and Nebrig have put together this 3-part volume to discuss how early childhood professionals can best guide and assist parents with the questions and issues that arise in the first 3 years of caregiving. Gowen, a writer, researcher, and former Associate Director of the Family, Infant, and Preschool Program in Morgantown, North Carolina, and Nebrig, the Director of the Child and Family Services Division of Trend Community Mental Health Services in Transylvania and Henderson Counties, North Carolina, explore how relationships — both between the parent and the child and the parent and other adults — are central to the healthy development of an infant. The first section focuses on this core principle, stressing that parent guides must be "reflective" — must question their own motives, behaviors, and feelings in their work — in order to cultivate caring, trustworthy relationships with parents, who will then do the same in their relationships with their children. This section contains a lengthy discussion of different infant temperament styles, includes tools to help caregivers assess infant attachment, and stresses concentrating on parents' strengths in order to nurture parents alongside children. The second section focuses on promoting emotional development during the first 2 years, laying out strategies for aiding parents in understanding a child's ability to regulate his emotions; using play to advance relationships; understanding the need for autonomy and support; and using empathy as a tool to understand the infant's needs. This section proceeds chronologically, breaking development into 3 main stages and focusing on the challenges and questions — crying; eating; sleeping; affect — that arise during each. The last section discusses "The Ghost in the Bedroom," detailing how a parent's history or family's structure can promote or challenge an infant's successful development. The role of the caregiving environment, the authors argue, is crucial to a child's development, and parent guides must encourage parents to utilize both internal and external resources to provide a healthy, productive atmosphere for growth.

Pathways to Competence: Encouraging Healthy Social and Emotional Development in Young Children

(2002) Sarah Landy, PhD (Paul H. Brookes Publishing Co., Post Office Box 10624, Baltimore, MD 21285, www.brookespublishing.com) Paperback. $54.95.

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With a foreword by ZERO TO THREE Board member Joy D. Osofsky, PhD, *Pathways to Competence* is a 500+-page volume developed to aid early childhood professionals in their interactions with the children and families they serve — and ultimately influence parent–child interactions. *Pathways* aims to translate research and clinical knowledge about infants' emotional development into practical strategies for focusing attention to emotional milestones alongside physical ones. The book's chapters address the major aspects of the social and emotional development of young children, including infant and child temperament; body control; positive body image; secure attachments; play and imagination; language and communication; positive self-esteem; discipline; and encouraging emotional regulation, concentration, problem-solving, and empathy in very young children. *Pathways* stresses that a child's emotional development is sequential, much like words following sounds in language development or walking following crawling in physical development. Illustrated throughout with vignettes and exercises, the book includes an analysis of major child development theories; tips for parents, caregivers, and professionals who work with parents; group activities for caregivers; a glossary of key terms; and an appendix on assessment tools. Each chapter contains tables and charts detailing skills attained at each stage of development, and lists of strategies for putting the knowledge about infant emotional development into everyday use while working with parents and children.

VIDEOTAPES

Learning & Growing Together With Families Video Package (2001)

Includes Seven Ways to Build Strong Relationships, *a 25-minute video with accompanying video guide, and Partnering With Parents to Support Young Children's Development, a book by Jeree Pawl and Amy Dombro. Purchase $69.00 plus shipping and handling. Available from* ZERO TO THREE, *2000 M Street, NW, Suite 200, Washington, DC 20036; 202-638-1144, fax: 202-638-0851, www.zerotothree.org.*

Designed for home visitors, Early Head Start staff, early intervention specialists, child care providers, and others who work with the families of young children, this video training package illustrates strategies for building strong, collaborative relationships with families and among colleagues in infant/family programs. *Seven Ways to Build Strong Relationships* shows practitioners working with families to promote the development of effective partnerships. The accompanying guide focuses on improving observational skills and connecting the concepts presented in the video to one's own practice. *Partnering With Parents to Support Young Children's Development* (also available separately) guides practitioners in reflecting on their work to recognize the powerful impact they have on children and families.

Learning Through Observation (2002)

Produced by Claire Lerner and Lisa Zbar. Purchase $64.95 plus shipping and handling. Available from ZERO TO THREE, 2000 M Street, NW, Suite 200, Washington, DC 20036; 202-638-1144, fax: 202-638-0851, www.zerotothree.org. 60 min.

This video was developed for supervisors, trainers, and program directors to use with front-line staff at all levels. Content areas include social/emotional development of very young children, working effectively with families, and developmentally appropriate practice in infant/toddler group care. The video provides non-narrated footage of real-life interactions between the staff of infant/family programs and families in a variety of situations. These include home visits (in the context of Early Head Start), family support and early intervention, and drop-off and pick-up times at child care. The User's Guide allows a facilitator work with trainees to refine general observation skills, explore the meaning of parent–child interactions, examine parent–staff interactions, consider options for meeting the needs of parent and child, and identify differences in individual children and families.

Just Being Kids (2001)

Produced by Larry Edelman, JFK Partners, Project Enrich, and the Colorado Department of Education. Purchase $75 (nonprofit) $125 (corporate and international) plus shipping and handling. Available from Western Media Products, PO Box 591, Denver, CO 80201; 303-455-4177, fax: 303-455-5302, www.media-products.com. Includes 55-page Facilitator's Guide. 50 min.

Providing supports and services for infants and toddlers with special needs in the context of a family's everyday routines, activities, and places (also known as "natural environments") is supported by research and federal public policy (Part C of the Individuals with Disabilities Education Act). This video illustrates this approach with 6 stories, each of which shows a therapist or early childhood specialist working with a family in its natural environment to achieve meaningful goals for the child. In each story, the parents and providers reflect on their experiences. The Facilitator' Guide offers trainers, educators, and team leaders background information on the stories, along with suggestions for leading discussion groups and other training activities.

The Nature of Positive Touch: Using Touch to Support Growth and Development in Young Children (2002)

Produced by the Teaching Research Division, Western Oregon University. Pur-

chase $50 plus shipping and handling. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401; 800-405-8942, fax: 818-994-0153, ChildDevelopmentMedia.com. Available in Spanish. 26 min.

This 2-part video was developed for parents and home visitors. Part I of the video shows 4 basic positive touch strokes parents can incorporate into daily routines in order to encourage brain development, enhance growth and development in premature infants, and relate to young children with special needs. Part II of the video is designed for home visitors who want to incorporate positive touch activities into their teaching techniques. A number of home visitors share their insights and guidelines for incorporating positive touch into the services they provide.

It Makes Sense: Providing Services in the Natural Environment (2002)

*Produced by SKI*HI Institute. Purchase $50 plus shipping and handling. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401; 800-405-8942, fax: 818-994-0153, ChildDevelopmentMedia.com. 24 min.*

This video shows early interventionists providing services to children with special needs and their families from birth to 3 in a variety of daily family routines and familiar settings. Children, parents, and early interventionists are seen, for example, in a swimming pool, on the playground, at a community-based music and movement class, at home during a meal, and outdoors at play. The parents and professionals describe the intervention and the benefits of providing services in a natural environment.

Seeing Is Believing (1999)

Includes practice tape and manual. Produced by M. F. Erickson, Irving B. Harris Training Center for Infant and Toddler Development, University of Minnesota. Purchase $65 plus shipping and handling. Available from Irving B. Harris Training Center for Infant and Toddler Development, University of Minnesota, 51 E. River Road, Minneapolis, MN 55455-0345; 612-624-4510, http://icd.coled.umn.edu/HarrisCenter. 40 min.

Seeing Is Believing describes a videotaping strategy for helping parents increase their sensitivity and responsiveness to a baby's signs and cues. The home visitor or facilitator is trained to videotape parent and baby in short sequences as they go about their everyday activities (e.g., feeding, bathing, and playing). Together, the parent and home visitor discover the unique characteristics of the child. By joining the parent in these observations, the home visitor can enhance the parent's ability to read the baby's cues and signals and to meet the needs of the baby appropriately. At the end of the work together, the family keeps the video as a visual document of the baby's development.

On-Line Resources

Guide to Careers in Child and Family Policy

www.igpa.uillinois.edu/cfp

Maintained by the Institute of Government and Public Affairs at the University of Illinois and the School of Education and Social Policy at Northwestern University, the Guide to Careers in Child and Family Policy aims to provide "validation, insight, and ideas for child and family policy careers." The site contains 2 major sections, "For Information Seekers" and "For Information Providers." Information seekers at any stage in their careers can browse field descriptions; academic programs; nonprofit, private, and government institutions; and numerous job, fellowship, intern, and volunteer opportunities. Information providers can list their organizations, browse other institutions in the field, and post internships, fellowships, volunteer positions, and job openings.

Illinois Early Learning (IEL)

www.illinoisearlylearning.org

The IEL Web site is Part of Futures for Kids, which supports education initiatives from birth through the teen years in the state of Illinois. Educational, health, and safety tip sheets on a variety of subjects of interest to parents and caregivers of very young children are available for download. How-to's include a series of techniques to advance science, math, music, and literacy readiness in toddlers; methods for child care programs to promote literacy during the toddler years; strategies to prevent lead poisoning in children; ways to get children to like healthy snacks; methods to keep children safe in the car; ways to deal with a very curious child; and ideas for sharing books with babies and toddlers. The site sponsors online chats with experts regularly, and the site's features are also available in Spanish.

Kansas Kids: A Prescription for Change

www.kansaskidshealth.org

The Web site for the radio program of the same name, "Kansas Kids" was developed to provide in-depth reporting on issues that affect the health and well-being of children. The site's audio archive contains programs on topics such as sleep, flu shots, grandparents, infant mortality, Early Head Start, child care quality, allergies, and lead poisoning. Recently, child and adolescent psychiatrist Martin Maldonado, a graduate ZERO TO THREE Fellow and director of the Family Service & Guidance Center of Topeka, was featured in a roundtable

discussion about infant mental health. (The clip is directly accessible at http://www.kansaskidshealth.org/archive/Infant_Mental_Health/.) In addition to the audio file, each archived program includes links to other web sites of interest on that program's topic — for example, Maldonado's program page lists links to ZERO TO THREE and the World Association for Infant Mental Health, while a program on infant mortality links to recent statistics on infant mortality in Kansas, a SIDS clearinghouse, and the National Center for Health Statistics.

The American Academy of Pediatrics

http://www.aap.org/terrorism/index.html

With the subhead "Disaster Preparedness to Meet Children's Needs," this Web site suggests how parents can best respond in the event of a terrorist attack or natural disaster. The site has four starting areas — "Topics," "Parents/Teachers/Community," "What's New," and "Featured Websites" — each a gateway to a constellation of resources. (For example, "Topics" lists biological, chemical, and nuclear agents. Clicking on "Biological Agents" takes you to a list of medical, technical, and instructional resources on anthrax.) The "Parents" section includes a link for pediatricians on the emotional needs of their patients during a time of crisis; a primer for creating a "Family Disaster Plan"; and a "Family Readiness Kit," which focuses on preparedness for natural disasters such as hurricanes, tsunamis, and earthquakes. "What's New" has the latest reports and recommendations, such as 9/11's lasting effects on children and whether the new smallpox vaccine is necessary, and "Featured Websites" includes links to sites such as the American Association of Poison Control Centers and the Infectious Diseases Society of North America.

The National Center for Children in Poverty

www.nccp.org

The National Center for Children in Poverty (NCCP), part of the Mailman School for Public Health, Columbia University, works to alleviate and mitigate the circumstances of children living in poverty, which may have an adverse effect on their healthy growth and development. The Web site details the 4 goals of the Center — 1) To define the scope and nature of the child poverty problem through research; 2) to identify programs and policies that work through systemic analysis; 3) to stimulate new research and its application; and 4) to disseminate facts about child poverty through a dynamic communications program. The center's home page divides recent research into sections for the media, policy makers, caregivers, parents, researchers, and professionals. "Media Resources" boils down recent research into a list of downloadable reports on topics such as American's views on people in poverty, state-by-state comparisons on child poverty programs, and stereotypes of children in poverty. The quarterly newsletter, *News and Issues*, which contains articles on topics such as school readiness and the effects of 9/11 on families in poverty, is available by order or in PDF form for download. "Child Poverty Facts" is a list of fact sheets and statistical reports on child poverty in the US, while "State and Local Info" links to *Map and Track*, a series produced by the center that tracks the success of state initiatives on children in poverty. (Highlights and information on individual states are available on the Web site.) The child care sections lists recent reports on informal child care arrangements, child care voucher use in several states, and a history of preschool and the poor in America, while the "Family Support" area maintains a series of reports under the heading, "Young Children And Families Under Stress: Preventive Health And Mental Health." The site also has an area focusing on welfare reform, and a comprehensive research forum and database allow outside research on children in poverty to be disseminated and discussed under the auspices of the NCCP.

Developmental Milestones

Kathryn E. Barnard, RN, PhD, and **T. Berry Brazelton, MD,** both **Past Presidents of ZERO TO THREE,** have received the 2002 Gustav O. Lienhard Award for the advancement of personal health services from The Institute of Medicine (IOM) of the National Academy of Sciences. Barnard, founder and director of the Center for Infant Mental Health and Development at the University of Washington, is only the fourth nurse to receive the Lienhard Award in its 17-year history. She is being honored for developing evidence-based assessment and parent education protocols that are used worldwide and have revolutionized clinical practice with infants and their parents. Most state departments of health either recommend or require that staffs receive Nursing Child Assessment Satellite training, a program Barnard pioneered in 1976. Brazelton, president and chair of The Brazelton Foundation, Inc., is being honored for changing the world's understanding of infant and child development over the last half-century through the publication of scholarly papers and more than 30 books, the training of hundreds of pediatric fel-

lows and residents, and the development of the Neonatal Behavioral Assessment Scale. Additional information about Barnard, Brazelton, and the Lienhard Award can be found at www.iom.edu/lienhard.

Harriet Meyer, a **ZERO TO THREE Board member** and president of the **Ounce of Prevention Fund,** a nonprofit organization that invests in the healthy development of children and families through early childhood development initiatives, received the **YWCA of Metropolitan Chicago Outstanding Achievement Award for Community Leadership** in October 2002. As president of the Ounce for the past 11 years, Meyer has guided the organization's expansion into many areas, including the development of Early Head Start services and the recent construction of the Early Childhood Educare Center to serve families on Chicago's South Side (see "Great Expectations," *Zero to Three*, December 1999/January 2000). She has also guided the creation of school-based health centers in Chicago and the establishment of a nationally recognized child sexual abuse prevention program, Straight From the Heart.

Peter Dawson, MD, MPH, a **ZERO TO THREE Graduate Fellow,** was named **Colorado Man of the Year** by **The Colorado Federation of Business and Professional Women (BPW)** in August 2002. Dawson, a pediatrician, works at the People's Clinic in Boulder, Colorado; teaches Maternal and Child Health at the University of Colorado; and is co-author, with **Graduate Fellow Daniel Kessler, MD,** of *Failure to Thrive and Pediatric Undernutrition: A Transdisciplinary Approach*.

The **Oklahoma Institute for Child Advocacy, Kentucky Youth Advocates, Agenda for Children** (Louisiana), **South Dakota Coalition for Children, Maine Children's Alliance** and **Colorado Children's Campaign** now comprise the state advocacy arm of the **Better Baby Care Campaign,** a partnership project of **ZERO TO THREE** aimed at improving the quality of child care for infants and toddlers. Each of these 6 state child advocacy organizations receives a $15,000 grant from the **National Association of Child Advocates (NACA)** to move an infant and toddler policy agenda forward in its state. The grants are made possible by **The David and Lucile Packard Foundation.** Grant recipients will use the money for nonpartisan analysis and public education activities around infant and toddler child care matters, such as those highlighted in "Caring for Infants and Toddlers," the Spring/Summer 2001 issue of The David and Lucile Packard Foundation's journal, *The Future of Children*.

The **Child Care Bureau, U.S. Department of Health and Human Services,** has awarded a 3-year contract to **ZERO TO THREE** to establish the **National Infant and Toddler Child Care Initiative.** ZERO TO THREE will work collaboratively with state child care administrators to help advance systematic improvements to infant and toddler child care. The Initiative will collect, produce, and disseminate information and resources and help states develop or implement plans to support strategic initiatives and evaluate progress.

Remembering Al Solnit

Continued from page 2

I was a few months into my promotion as a (very) Assistant Professor of Psychiatry on Al Solnit's faculty when I *thought* I heard, in one of Al's clinical discussions, some hedging about the importance of early intervention. With arrogance characteristic of the young and uninformed, I spoke up. Al paused, looked at me with Old Testament intensity, and said very slowly, "Kyle, n-e-v-e-r question my belief in early intervention. You need to listen more and talk less." Chastened and not a little embarrassed, I avoided him until he came to my diminutive office a few days later to chat. It seems that he and Sally Provence had decided I needed some time with Anna Freud and wanted to make that happen.

This was vintage Al — passion, challenge, diagnosis, faith, adventure, and, finally, solution in growth. So many have felt the exhilaration of his belief in and idealization of us. Others have felt the sting of his righteous, informed charge that we are letting our children down by talking too much and listening too little. We are all Solnit Fellows†.

Al's accessibility was simply remarkable, and somehow, in the face of his intellectual and ethical excellence, out of place. He wanted us all to call him "Al." When he conducted pediatric rounds, he wore the white jacket of the student, not the long white coat of the attending physician. His loss was never going to be easy, and somehow we knew he would never get caught going "gently into that good night." He would resent (and chide me for) how diminished I feel by losing him so early, and tell me to get back to work. In this era of contracted and leery spirits, Al — we hardly knew ye.

Kyle Pruett
Past President
ZERO TO THREE

* T. Berry Brazelton, Stanley Greenspan, Ron Lally, Bernard Levy, Peter Neubauer, Robert Nover, and Julius Richmond.

† Irving B. Harris, supporter of the component of ZERO TO THREE's Leadership Development Initiative targeted to individuals at the outset of their careers, named these leaders "Solnit Fellows."

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Where Program Leaders Turn for Ideas...

Each day, infant/family program leaders face multiple demands in supervising and supporting staff's efforts to provide the highest quality services to families. The ZERO TO THREE Center for Program Excellence—a nationwide training and consultation network—has developed a new, powerful training resource entitled *Reflective Supervision in Practice: Stories from the Field.*

Announcing a new resource on Reflective Supervision...

Reflective Supervision in Practice follows four infant/family programs as they implement reflective supervision, an approach characterized by mutual respect, collaboration and open communication between supervisors and staff. Challenges and benefits of the change are explored. Discussion questions and suggested activities are provided to facilitate both individual and group learning. This resource is especially useful for leaders considering the implementation of reflective supervision in their programs and trainers in program improvement.

To order, contact ZERO TO THREE's Customer Service Department at 1-800-899-4301 or www.zerotothree.org

(2002) ISBN: #0-943657-59-8; $15

Upcoming Issues

January 2003 — The Impact of Adult Relationships on Early Development: The relationships that adults have with other adults — particularly the relationship between a baby's parents or other close relatives or supporters — affect parents' ability to build positive, secure relationships with their babies and young children. Bernadette Bullock and Marion Forgatch; Virginia Casper, Frank Furstenberg, and Judith Solomon; and Amy Susman-Stillman, Karen Appleyard, and Jessica Siebenbruner review the scientific literature in this area and report on their own studies of parents and young children in a range of family configurations.

March 2003 — Community Partnerships for Quality Infant/Toddler Child Care: With support from the Child Care Bureau and the Ewing Marion Kaufmann Foundation, ZERO TO THREE and Mathematica Policy Research have studied strategies for developing community systems to help families find infant/toddler care, blend funding sources to pay for care, and support providers to improve quality and develop professionally. This issue will feature case studies of community partnerships in Kansas City, KS; Sedalia, MO; Colorado Springs, CO; and Buncombe County, NC.

May 2003 — Caregiver Goals and Societal Expectations: Guest Editors for this issue are representatives of the infancy programs housed in each of the Four-College Early Childhood Consortium: Virginia Casper, Bank Street College of Education; Fran Stott, Erikson Institute; Renatta Cooper, Pacific Oaks; and Cathy Finn, Wheelock College. Articles in this issue will describe how different families and caregivers negotiate competing cultural models of child rearing, especially when familial goals do not match an early childhood program's or mainstream society's expectations.

The Editorial Mission of the *ZERO TO THREE* Bulletin

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

The Mission of ZERO TO THREE: National Center for Infants, Toddlers, and Families

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional, and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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EFF-089 (1/2003)

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